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HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

MARCH 16, 1959

SPECIAL 22-PAGE SECTION
ON PLANNING AND CONSTRUCTION

A SCULPTOR LOOKS AT HOSPITAL DESIGN (PAGE 68)

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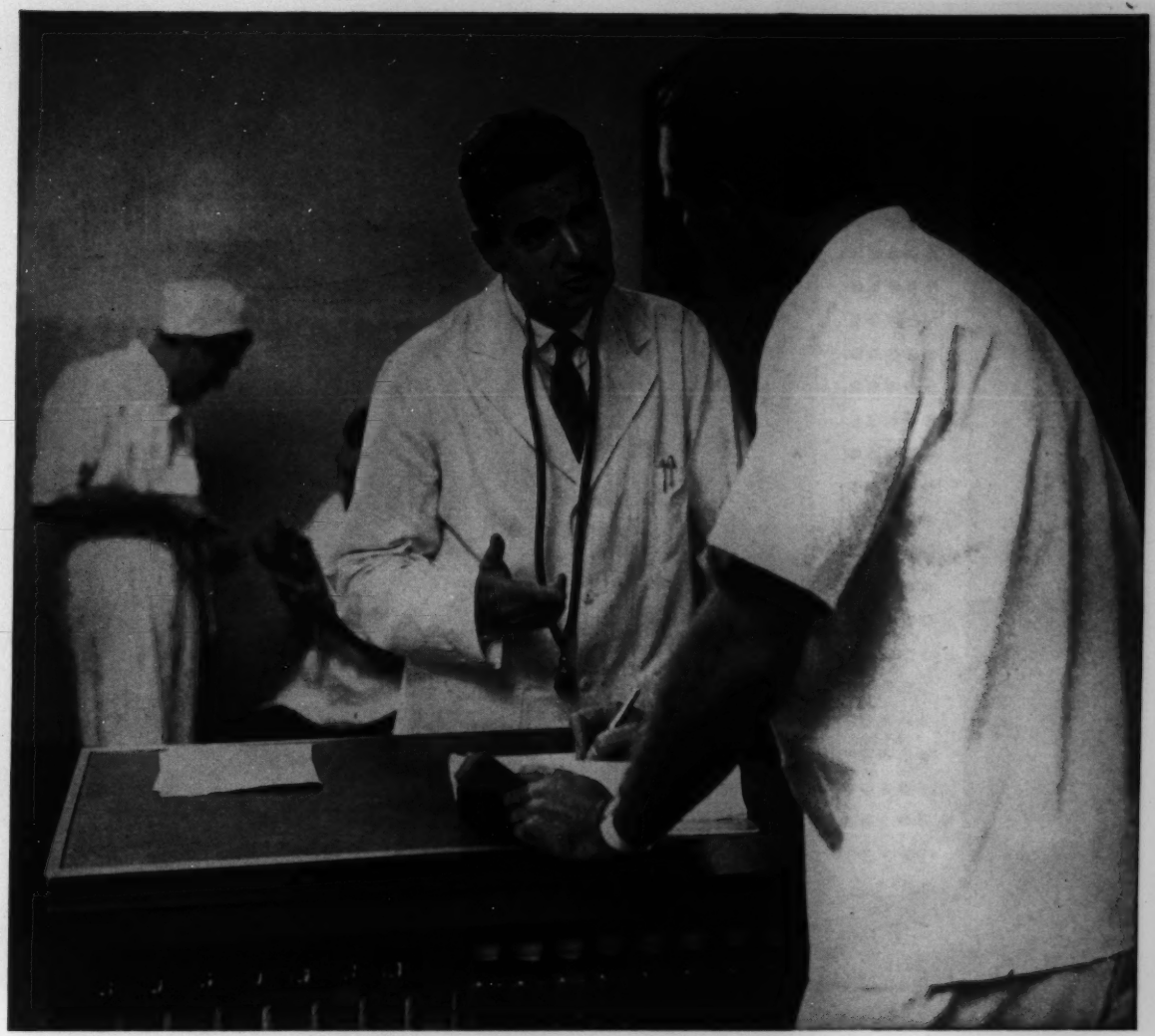

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1. Sher, D. B.: Aspirin and APC Irritation of the Stomach, Scientific Exhibit, World Congress of Gastroenterology; Washington, D.C., May, 1958.

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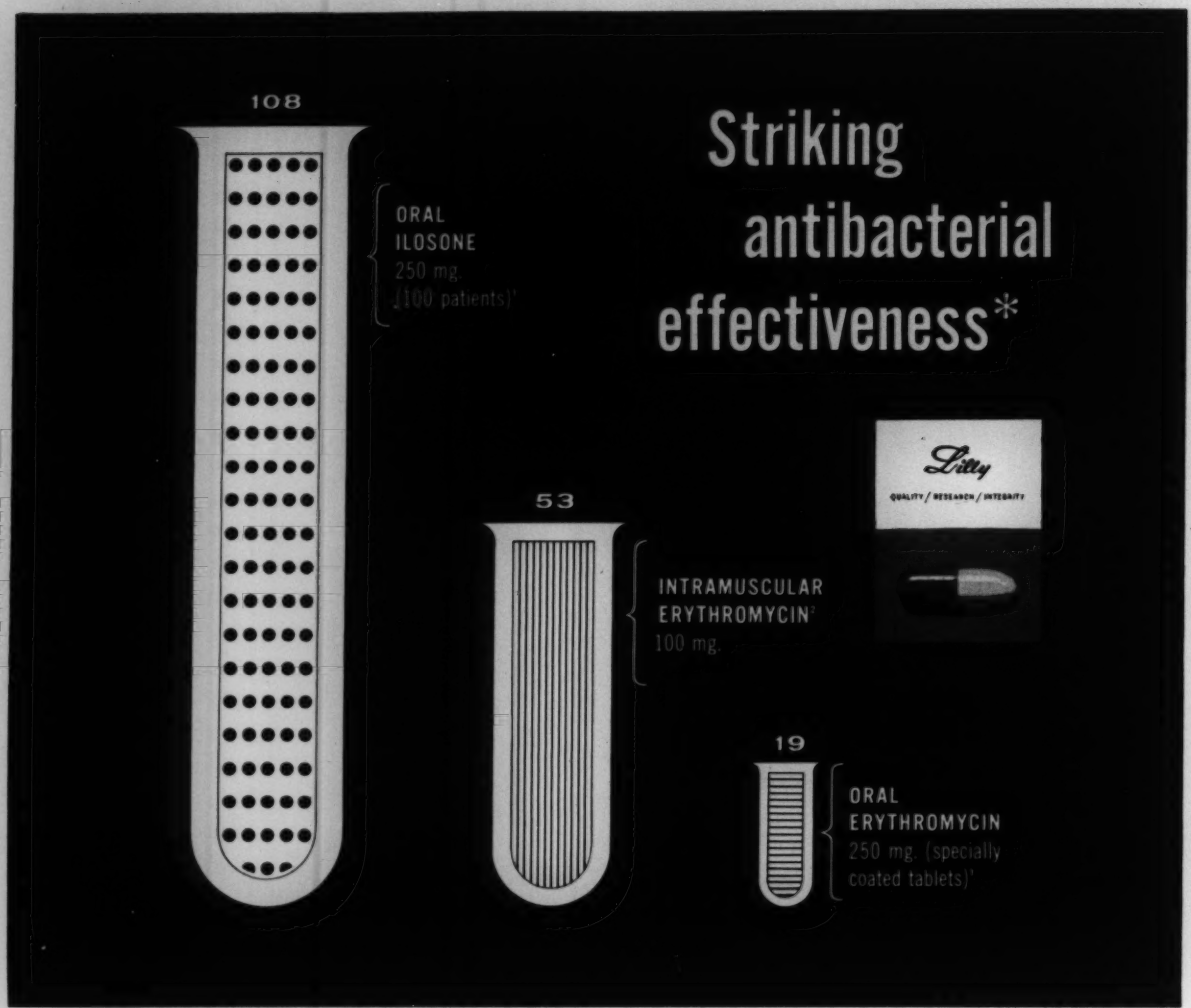

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1. Griffith, R. S., *et al.*: Antibiotic Med. & Clin. Therapy, *5*:609 (October), 1958. Note: Peak levels with the oral erythromycin tablets (thirty-three dilutions) were not observed until four hours after administration. 2. Data from Griffith, R. S.: Antibiotics Annual, p. 269, 1954-1955.

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cover

Marble pylons at entrance to basic sciences building at the medical center, West Virginia University, Morgantown, have reliefs on both sides sculptured by Milton Horn. An article by Mr. Horn describing the planning behind these pylons begins on page 68. Photo by Estelle Horn. (Other picture credits on page 158.)

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1959

Aug. 24-27—**61st annual meeting,** New York City (Coliseum; Statler Hotel)

1960

Aug. 29-Sept. 1—**62nd annual meeting,** San Francisco (Civic Auditorium)

MEETING AND INSTITUTE CALENDAR

THROUGH AUGUST 1959

(American Hospital Association institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. *Other organizations in the health field are shown in ITALICS.)*

MARCH

16-19 **Obstetrical Nursing Administration,** St. Louis (Coronado Hotel)
16-20 *National Health Forum,* Chicago
17-19 *National Health Council,* Chicago (Palmer House)
23-25 New England Hospital Assembly, Boston (Statler Hotel)
30-Apr. 3 **Dietary-Housekeeping-Nursing Department Relationship,** Chicago (AHA Headquarters)
31-April 2 Kentucky Hospital Association, Lexington (Phoenix Hotel)

APRIL

1-3 Mid-West Hospital Association, Kansas City, Mo. (Municipal Auditorium; President Hotel)
6-9 Ohio Hospital Association, Columbus (Veterans Memorial Auditorium; Deshler-Hilton Hotel)
6-9 *American Academy of General Practice,* San Francisco
8-10 Southeastern Hospital Conference, Atlanta (Atlanta-Biltmore Hotel)
9-10 New Mexico Hospital Association, Albuquerque (Western Skies Hotel)
12-16 *Annual Conference of Blue Cross Plans,* Chicago
13-17 **Workshop on Team Nursing,** Chicago (AHA Headquarters)
13-17 **Hospital Engineering,** Baltimore (Lord Baltimore Hotel)
15-17 **Regional Conference on Development of Principles for Planning the Future Hospital System,** Chicago (AHA Headquarters)
16-17 Carolinas-Virginias Hospital Conference, Roanoke, Va. (Hotel Roanoke)
20-23 **Evening and Night Nursing Service Administration,** Buffalo, N.Y. (Lafayette Hotel)
22-23 South Dakota Hospital Association, Huron
23-24 Iowa Hospital Association, Des Moines (Savery Hotel)
23-25 **Regional Conference on Development of Principles for Planning the Future Hospital System,** New Orleans, (Roosevelt Hotel)
27-29 Tri-State Hospital Assembly, Chicago (Palmer House)
27-May 1 *American Psychiatric Association,* Philadelphia
27-May 1 *National Association for Practical Nurse Education,* Cincinnati (Netherland-Hilton Hotel)
28-May 1 **Occupational Therapists,** Waco, Tex. (Roosevelt Hotel)
30-May 2 **Regional Conference on Development of Principles for Planning the Future Hospital System,** Salt Lake City, Utah (Hotel Utah)

MAY

4-7 Association of Western Hospitals, Salt Lake City, Utah (Utah Hotel)
4-8 **Dietary Department Administration,** Pittsburgh (Pick-Roosevelt Hotel)
6-8 *American Pediatric Society,* Buck Hill Falls, Pa.
7-8 Tennessee Hospital Association, Nashville (Andrew Jackson Hotel)
11-13 Canadian Hospital Association, Montreal (Queen Elizabeth Hotel)
11-14 Texas Hospital Association, Houston (Shamrock-Hilton Hotel)
11-15 *National League for Nursing,* Philadelphia (Convention Hall)
13-15 **Regional Conference on Development of Principles for Planning the Future Hospital System,** Washington, D. C. (Raleigh Hotel)
13-15 Upper Midwest Hospital Conference, St. Paul (St. Paul Auditorium; Lowry and St. Paul Hotels)

(Continued on page 155)

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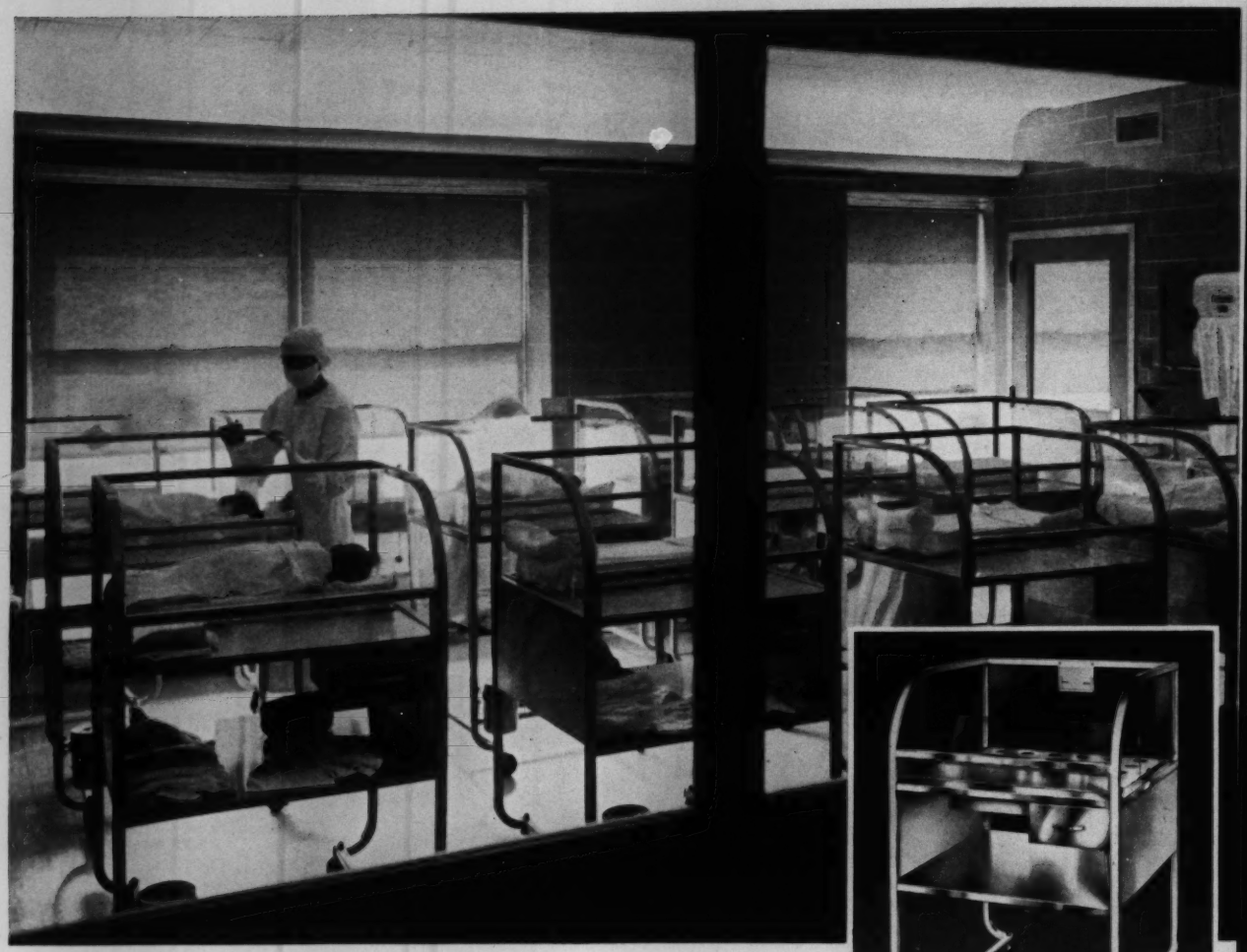

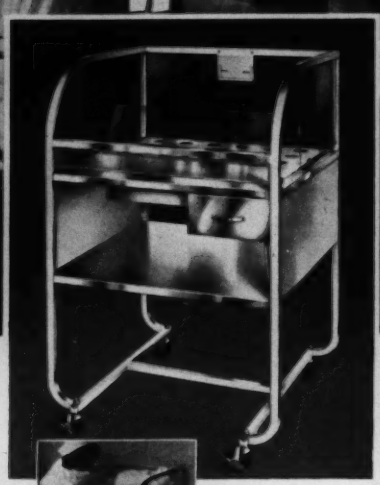

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Light Weight, Easily Mobile

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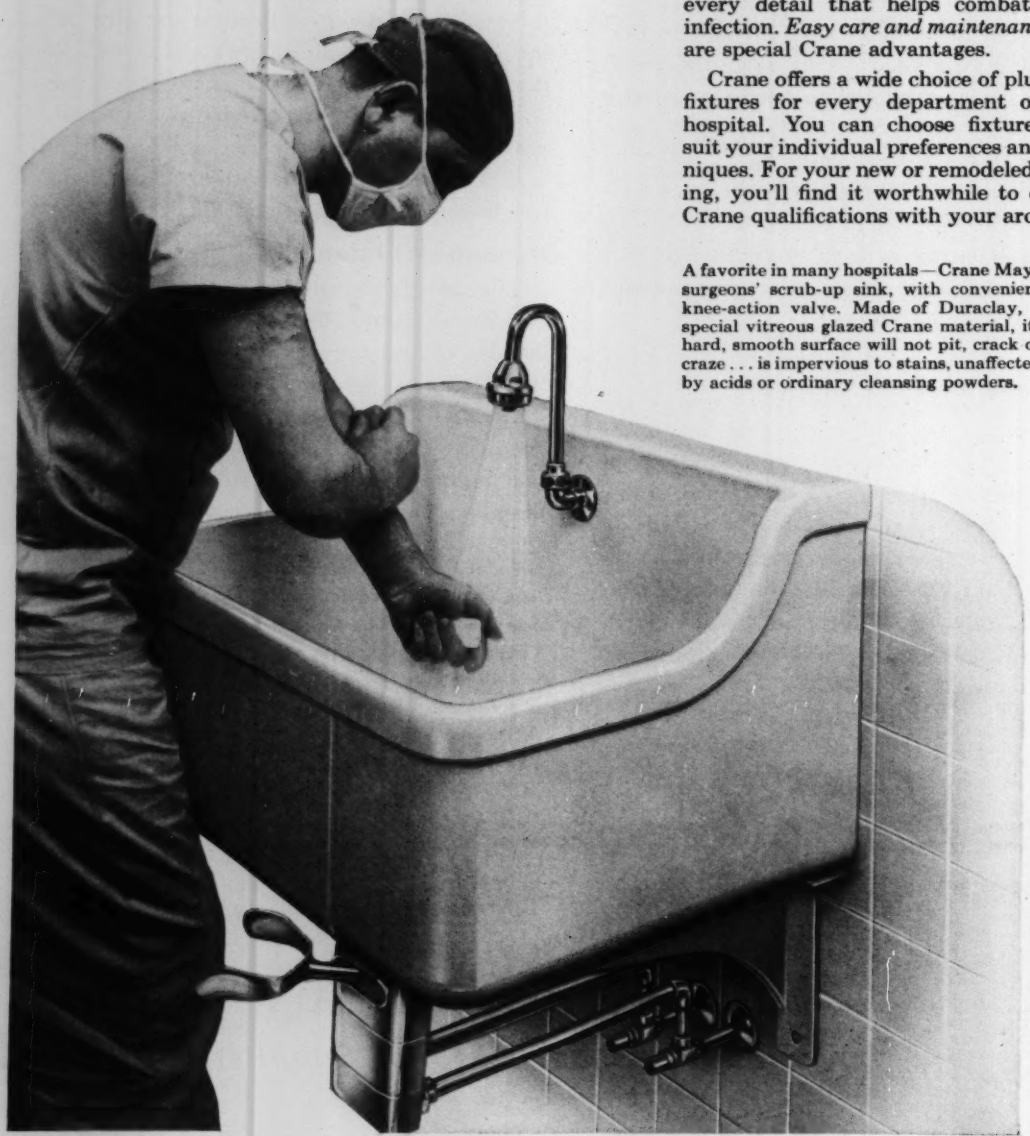
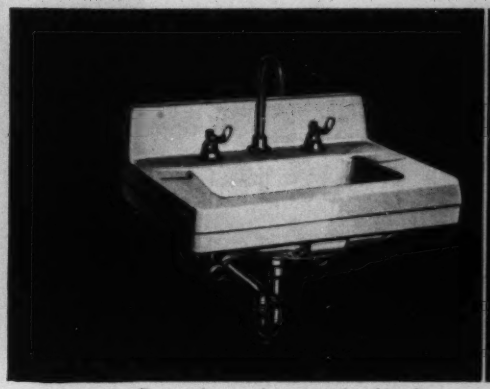
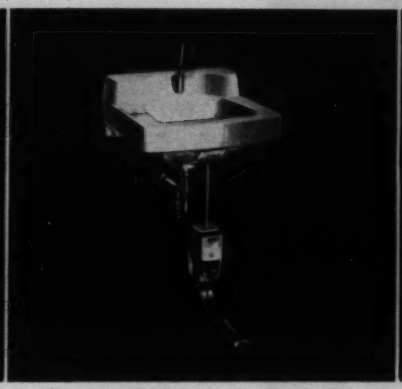


A favorite in many hospitals—Crane Mayo surgeons' scrub-up sink, with convenient knee-action valve. Made of Duraclay, a special vitreous glazed Crane material, its hard, smooth surface will not pit, crack or craze . . . is impervious to stains, unaffected by acids or ordinary cleansing powders.

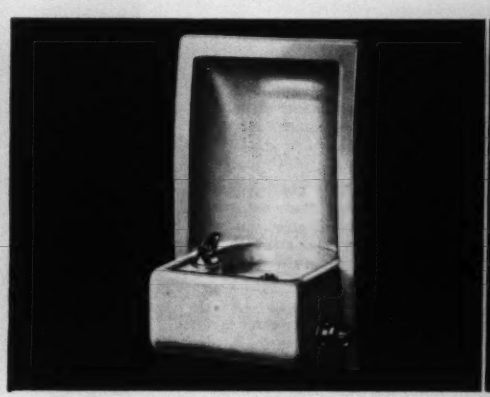


Convenient wrist operation is a feature of this Crane *Norwich* vitreous china lavatory. Gooseneck spout accommodates pitchers, vases, etc.

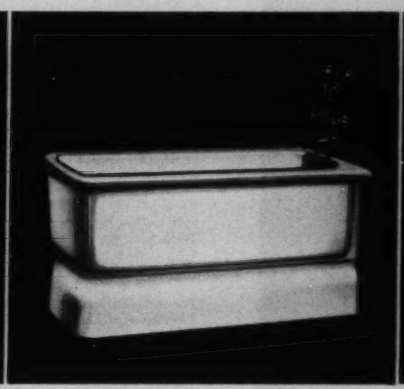


Foot-operated valve on Crane *Oxford* vitreous china lavatory prevents cross-infection. Hands never touch faucets.

Hygiene lavatory is ideal for patients' rooms. Available for right- or left-hand corner installation, also, without side splash.

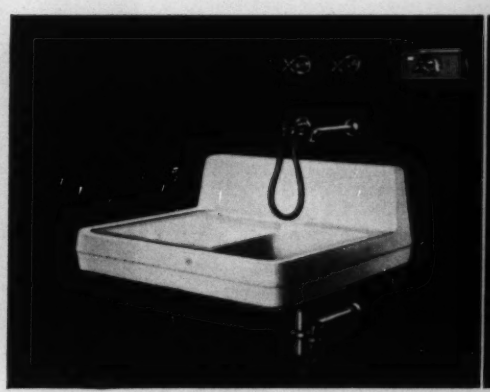


Crane *Coolbrook* vitreous china, semi-recessed drinking fountain has elevated bubbler base for maximum sanitation. Available with single or central water chiller.



Crane *Institutional* free-wall bath, to build into end wall. Made of durable cast iron with porcelain enamel finish. Cast iron base included.

A Crane exclusive—*Dial-ese* control—practically drip-proof because it closes *with* water pressure, not against it. All working parts contained in low-cost replacement unit.



Infants' bath made of Crane *Duraclay*. Smooth, vitreous china surface is kind to babies' skin. Includes 20-gallon tank with dial thermometer.

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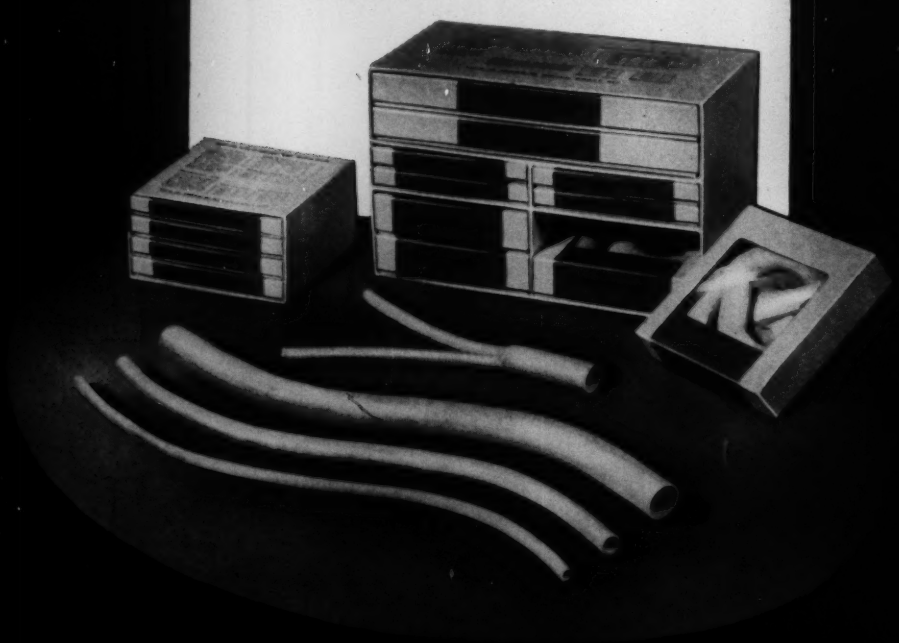

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introducing the authors

Donald C. Carner suggests that utilizing the services of a competent interior designer can lead to "a warm and comfortable atmosphere in a hospital" for patients and "it can pay in dollars and cents, too." Mr. Carner pinpoints the differences between services offered by building designers and interior designers (p. 50).

MR. CARNER

Mr. Carner has been administrator of 370-bed Seaside Memorial Hospital, Long Beach, Calif., since 1955. Prior to that he was administrator of Parkview Memorial Hospital, Fort Wayne, Ind.

He is a graduate of the University of Chicago program in hospital administration and is a fellow of the American College of Hospital Administrators. Mr. Carner has served on committees of the American Hospital Association and is currently active in the program of the California Hospital Association.

Milton Horn discusses the philosophy of hospital design (p. 68) from the point of view of a sculptor with more than 30 years experience. Mr. Horn has been working professionally as a sculptor since 1927. His work has been exhibited in leading museums across the country, including the Metropolitan Art Museum in New York. He has had 10 one-man exhibits.

MR. HORN

Mr. Horn was appointed artist-in-residence for Olivet (Mich.) College through a grant from the Carnegie Corporation to the college. In 1940 the college appointed him professor of art and chairman of the art department. Upon his resignation in 1949, Mr. Horn settled in Chicago, where he now has his studio.

In 1957, the American Institute of Architects conferred upon Mr. Horn their citation of honor. His other citations include the honor award given by the Chicago chapter of the AIA for "excellence in the fine arts allied with architecture."

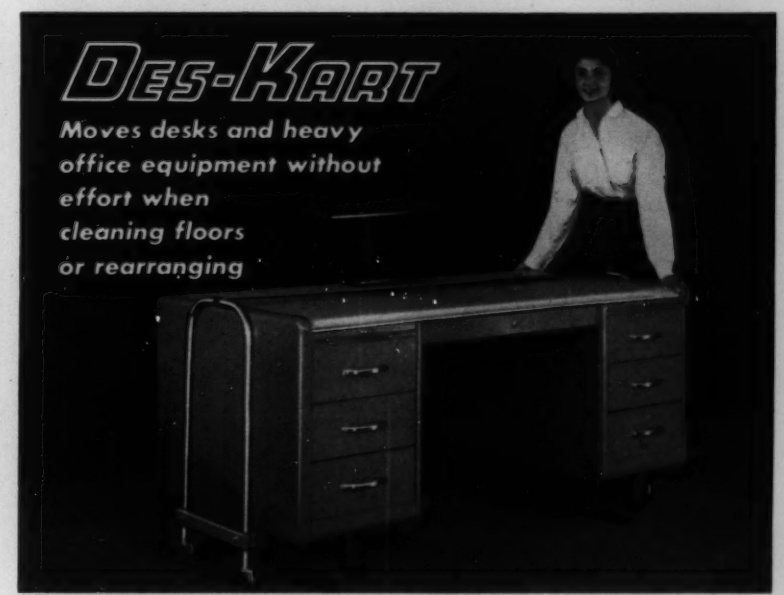
In addition to his work as a sculptor, Mr. Horn frequently serves as an author, lecturer and consultant. His work has been selected by the U. S. Information Agency for exhibition abroad.

Franz Lipp, a landscape architect whose assignments over the last 30 years have included many hospitals and nursing homes, believes that plants, grass and trees not only help to "humanize" hospitals but also play a fundamental role in the convalescence of patients. In an article beginning on page 53, Mr. Lipp lists various types of plants, explaining the purposes of each, and discusses factors influencing the durability of plants.

MR. LIPP

Educated at schools in Australia and Germany and at Harvard University in the United States, Mr. Lipp is a registered professional engineer in Illinois. He opened his office in Chicago in 1929.

His career in landscape architecture has included general land planning and engineering for institutional and industrial buildings, housing projects, country estates, and residences. Samples of his work for hospitals can be found in such widely separated cities as Morgantown, W.Va. (Medical Center of West Virginia University) and Wauwatosa, Wisc. (Milwaukee Sanitarium).



Busy maintenance personnel need no longer be called in when minor furniture rearranging is necessary and, after hours, desks may be easily moved for cleaning or buffing operations. The Des-Kart works on carpets or hard surface floors and spells an end to moving problems. No jack, no cranks, clean, simple—just slip the Des-Kart under either end of a desk and it's mobile.

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now...for edema and hypertension

Esidrix

(hydrochlorothiazide CIBA)

milligram-for-milligram
the most effective oral
diuretic-antihypertensive

Improved diuretic-antihypertensive; high degree of activity, low toxicity

Esidrix T.M.

(hydrochlorothiazide CIBA)

Greater activity: Milligram-for-milligram, Esidrix is the most effective oral diuretic known. With a therapeutic efficacy comparable to parenterally administered mercurials, Esidrix is from 10 to 15 times more potent than chlorothiazide and therefore provides the same therapeutic benefits with but 1/10 to 1/15 the dosage. Animal studies indicate that Esidrix is longer acting than chlorothiazide, providing a smoother response.

Low toxicity: According to animal studies, Esidrix is markedly less toxic than chlorothiazide and is therefore an exceptionally safe diuretic-antihypertensive.

Patients unresponsive to chlorothiazide and mercurials in many cases respond readily to Esidrix.

Use in hypertension: Esidrix may be used alone or in combination with other antihypertensive drugs to bring about effective lowering of blood pressure. The drug potentiates the action of all other antihypertensive agents, including SINGOSERP, SERPASIL and APRESOLINE. Dosage (and side effects) of other agents often can be reduced when they are given with Esidrix.

Less dietary salt restriction: In many cases, Esidrix permits some moderation in severe sodium restriction and therefore makes meals more palatable. Side effects are usually not severe and most of them can be overcome by adjusting the electrolyte balance (through dietary supplements), lowering the dose or administering the drug after meals.

Dosage: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day.

Supplied: TABLETS, 25 mg. (pink, scored); bottles of 100.
TABLETS, 50 mg. (yellow, scored); bottles of 100.

SINGOSERP T.M. (syrosingopine CIBA)
SERPASIL® (reserpine CIBA)
APRESOLINE® hydrochloride (hydralazine hydrochloride CIBA)

2/2668 MX-2

CIBA
SUMMIT, N.J.

B.F.Goodrich

An extra-soft rubber glove that reduces hand fatigue, fits comfortably without binding

Softer than other gloves; stronger and just as thin

"Less tiring to my hands", "Doesn't restrict my fingers", ". . . almost forgot I had gloves on", are typical comments made by surgeons who are using "Surgiderm" gloves, developed by B.F.Goodrich.

Testing machines—which measure the softness and strength of rubber—prove that the "Surgiderm" glove is 30 to 50 per cent *softer* than any regular rubber surgeon's glove. This means that it is:

Less tiring to the hands

Because it's more pliable, it fits easily, snugly—doesn't bind the hand or restrict the freedom of the fingers. Less force is needed to flex the fingers and that's what reduces hand fatigue. The difference is so obvious you can feel it just by putting the B.F.Goodrich "Surgiderm" glove on one hand and comparing it with any other rubber glove on your other hand.

Permits sensitive touch

The glove is tissue thin all over—no heavy ends at fingertips. This allows almost as sensitive a touch as a surgeon would have without gloves.

Stronger, longer lasting

The use of a specially-developed rubber compound makes this B.F.Goodrich glove extra strong to start with and it stays strong even after a dozen sterilizations.

Test a pair

Ask the glove buyer at your hospital to get a pair of B.F.Goodrich "Surgiderm" gloves for you. We think when you compare them with the gloves you are now using, you'll be convinced that these B.F.Goodrich gloves are the most comfortable you've ever worn.

They cost no more

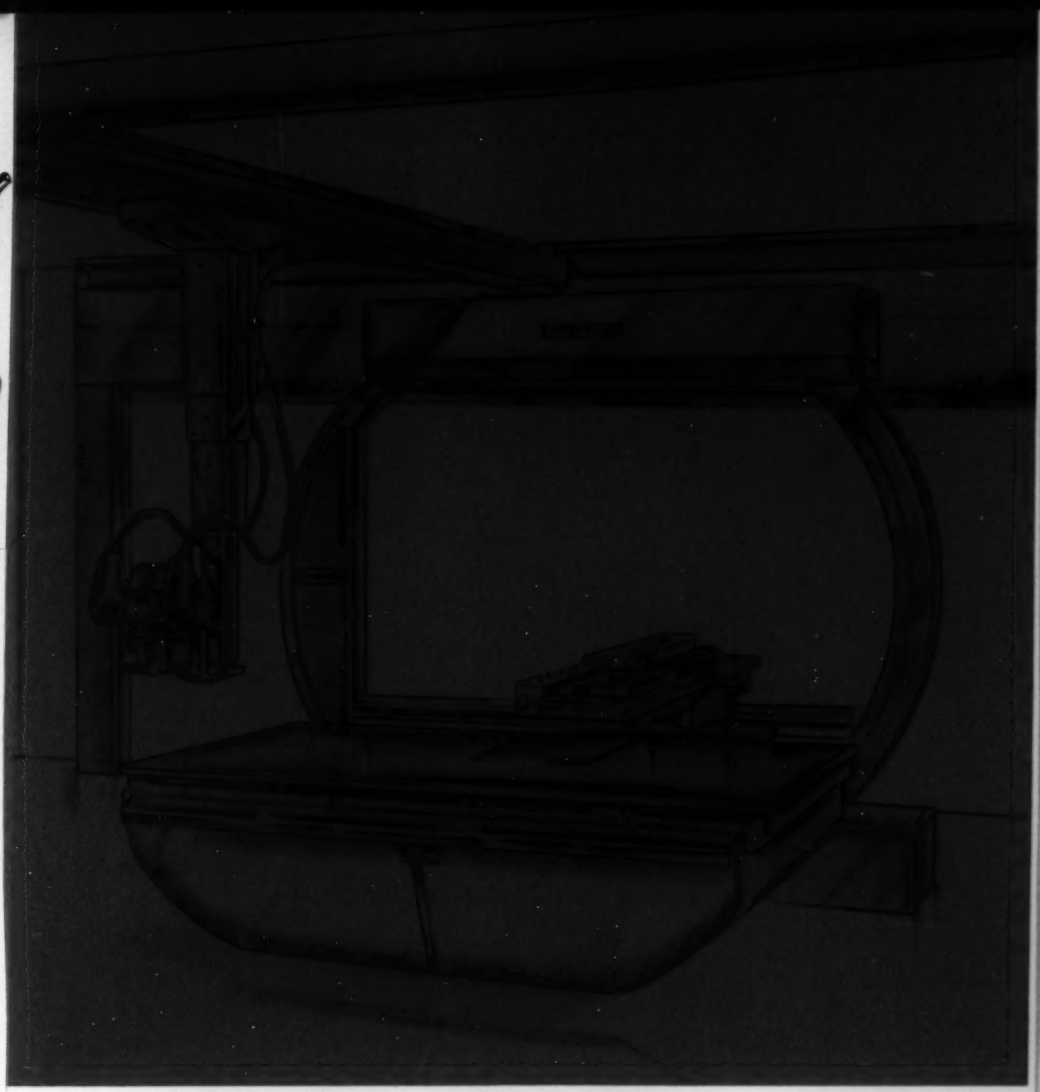
Since this glove is the only one that combines comfort and sensitivity with strength—you might expect it to be expensive. The fact is it costs no more than many regular rubber gloves being sold today. In the long run, it really costs less because it can be used for more operations.

Where to buy

B.F.Goodrich "Surgiderm" gloves are made in sizes from 6 to 10, are brown in color. Try a pair soon. They're sold by hospital supply houses and surgical dealers everywhere. *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Co., Akron 18, Ohio.*

B.F.Goodrich *hospital and surgical supplies*

Imperial II



Above: a unit born of the conviction that x-ray diagnosis deserves undivided share-of-mind — unencumbered by limitations of movement, unconcerned with operating detail. It is, in fact, a design guided by radiologists themselves.

A new mark of x-ray excellence

General Electric introduces the Imperial II — paragon of every diagnostic virtue. It is a unit for those who acknowledge the immeasurable benefits of ease, efficiency and refusal to be overtaken by obsolescence — who realize that these values make first cost secondary.

There follow a number of intimate and interesting revelations concerning the Imperial II.

Imperial II

Lets nothing stand in the

Meet the Imperial II . . . at whose table x-ray diagnosis becomes a matter of technique, not physique. A unit so willingly responsive, using it shortly becomes a reflex action — so flexibly functional, it performs as an extension of the radiologist himself. To elaborate—

- The remarkably easy handling of its spot-film device is truly *"reflexomatic"* — so maneuverable it asks no more effort than a hand shake.
- Fluoroscopic shutters are operated by a new direct-linkage mechanical control. Hence, they respond instantly, with no lag . . . gently, with no lash . . . *"reflexomatic."*
- Fully *"reflexomatic,"* too, is t weightless overhead tube hanger. ging cables it steers lightly, precise along the length and breadth of beyond within a 12 x 12-foot area. plifies cross-table and cart radiogra way limits the placement of auxili about the room.
- There is no cable weight to cables disappear into the overhe which the tube hanger is suspende where positioned — no cable pull

So it goes with all aspects of th

he way of your diagnostic skill

o, is this seemingly
nger. With no drag-
precisely to any spot
th of the table and
t area. Thus, it sim-
diography . . . in no
auxiliary equipment

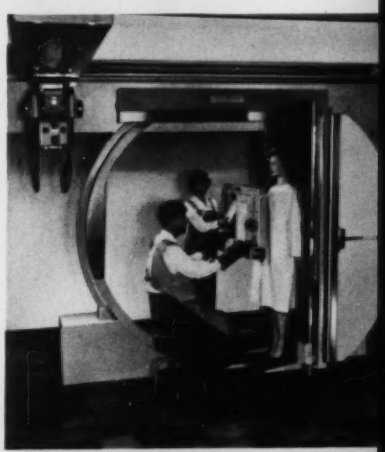
t to fight. In fact,
overhead rail from
spended. Tube stays
e pull to disturb it.
s of the Imperial II

. . . endowed with every new and known resource to enhance the skills of the man in the lead apron.

You will find further exposition of the Imperial II's features on the following page.

FLUOROSCOPY WITH FACILITY

As if independent of gravity, the spot-film unit glides into position almost by suggestion. This *"reflexomatic"* action not only precludes physical taxation but also speeds fluoroscopic positioning . . . and thereby, patient flow. And, as illustrated, it even works left-handed.



"What do you want in diagnostic equipment?"

. . . we asked. And radiologists responded:

". . . a fully automatic spot-film unit."

With the Imperial, you dial the number of exposures—up to four on a film. Its 18 exposure areas are all automatically sequenced. Double exposures are impossible.

". . . phototiming consistency even when shooting spot-films in a lighted room."

The G-E phototimer is a sealed unit. Extraneous light cannot affect its accuracy, nor can dust coat the viewing screen.

". . . constant viewing relationship during table angulation."

Because the spot-film unit, like the table, is ring-mounted, screen-to-eye relationship is constant—always at or near the center of the pivoting ring.

". . . an easier way of loading cassettes."

They snap into place with slight pressure on the latch. And by lightly pressing the ejector, the cassette pops instantly into your gloved hand.

". . . accurate radiographs of the area visualized in fluoroscopy."

The Imperial's three synchronized scales assure fool-proof tube-film alignment. They indicate previous position of the parked spot-film unit, desired positions of both Bucky diaphragm and x-ray tube.

". . . an easier-to-handle tube support."

With the *"reflexomatic"* Imperial there is no cable pull—its telescoping tube support is counterbalanced for easy movement to any position. Correlating scales assure precise alignment with related radiographic components.

". . . greater Bucky travel."

The Imperial Bucky has a 49-inch travel range.

". . . more flexibility in radiographic technics."

The tube hanger permits "behind table" technics to be performed from the front . . . using preferred distances and positions.

". . . more mobility for hospital-cart radiography."

Bi-lateral movement of overhead tube hanger gives complete coverage of a 12x12 area.

". . . prompt, considerate service."

General Electric offers the broadest service facilities in the field of x-ray. Supplies, repairs and parts, installation planning are all available through your local General Electric X-Ray office.

Should you wish to pursue the details of the Imperial II further, please contact your General Electric x-ray representative. An alternative: write us directly. X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Rm. 1902.

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digest of NEWS

HOSPITAL FACES 'CORPORATE PRACTICE OF MEDICINE' ALLEGATIONS—A charge of "corporate practice of medicine" has been lodged against Spartanburg (S.C.) General Hospital by radiologists who practice at the hospital.

The radiologists charged in their complaint that actions of the hospital board and the county that seek to limit the income of radiologists are "invalid, discriminatory and unconstitutional." Details p. 127.

REPORT FROM WASHINGTON—The present method of financing construction of student nurse and intern housing would be terminated, if a resolution introduced in the House by Rep. Howard W. Smith (D-Va.) is passed. Details p. 119.

- The omnibus housing bill, which carries provisions for loans for student nurse and intern housing, has been reported out of the House Banking and Currency Committee. The bill may face opposition from Rep. Smith, who was responsible for killing a similar measure last year. Details p. 119.
- A bill to utilize the federal social security mechanism as the means for providing hospital-medical care for the aged has again been introduced in the House by Rep. Aime J. Forand (D-R.I.). Details p. 120. Sen. Hubert Humphrey (D-Minn.) introduced a similar bill in the Senate. Details p. 120.
- Another bill concerned with health on a national basis was introduced in the House and Senate. It is the Murray-Dingle insurance proposal and is substantially the same as the Wagner-Murray-Dingle bill introduced in Congress 14 years ago. Details p. 120.
- Action on a program to provide medical care for federal employees has been postponed. Details p. 120.
- A Senate committee investigation of hospital costs is tentatively scheduled to begin later this month. Details p. 120.
- A five-year extension of the federal aid program for graduate nurses training for advanced positions is sought in a bill introduced by Sen. Lister Hill (D-Ala.). Details p. 121.
- Bills have been introduced in the House and Senate to provide federal aid for college training of professional nurses. Details p. 121.

GORMAN URGES INSURANCE COVERAGE FOR MENTAL ILLNESSES—Health insurance plans should provide a minimum of 30 days of hospital-medical coverage for mental illnesses, Mike Gorman, executive director, National Committee Against Mental Illness, said in recent testimony before the New York Joint Legislative Committee on Health Insurance Plans. Details p. 127.

DR. BATES ACCEPTS BALTIMORE HOSPITAL POST—Dr. LeRoy E. Bates has accepted the directorship of Union Memorial Hospital, Baltimore, effective March 31. Dr. Bates is assistant director of the American Hospital Association, director of AHA's Department of Professional Services, and secretary of the Association's Council on Professional Practice.

Dr. Edwin L. Crosby, AHA director, announced that:

- Dr. Madison B. Brown, AHA associate director, has been named director of the Department of Professional Services and will be secretary of the Council on Professional Practice.
- Richard L. Johnson has been named an assistant director of the Association. Details p. 130.

NEW YORK CITY SURVEYS COST, CARE IN HOSPITALS—A 38-member commission of industry, labor, and health field representatives has been appointed by New York City Mayor Robert Wagner to recommend cost-cutting measures for hospitals and ways of improving patient care.

The committee is also to formulate a plan for coordinating public and private hospital services.

David M. Heyman, president of the New York Foundation, a founder of the Health Insurance Plan, and a member of New York City's Hospital Board, is chairman of the committee.

Henry C. Brunie, president of the Empire Trust Co. and chairman of the United Hospital Fund, and Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation of the New York University-Bellevue Medical Center, are vice chairmen of the group.

Hospital administrators on the committee are: Dr. George E. Armstrong, director, NYU-Bellevue Medical Center; Edward F. Butler, director, St. John's Hospital, and Dr. Martin Cherkasky, director, Montefiore Hospital. Hospital Commissioner Morris A. Jacobs, Health Commissioner Leona Baumgartner, and a number of doctors and hospital trustees are also members of the commission.

In commenting on the work of the commission, Mr. Heyman said that a system of progressive patient care—making the whole array of hospital services available to the critically ill, but providing less complicated and less expensive services to those patients who are not in critical condition—will be studied.

GEORGIA HOSPITAL ASSOCIATION SEEKS MERGER OF BLUE CROSS PLANS—Trustees of the Georgia Hospital Association have recommended that Blue Cross-Blue Shield Plans in the state merge their operations.

Worth Quoting

". . . Those who cannot adjust to circumstances are likely to be dominated by them . . ."—**Michael Davis, Ph.D.,** ***hospital consultant, at the first National Conference on Labor Health Services, June 16-17, 1958, Washington, D.C.***

Following is the text of the recommendation:

"The trustees of the Georgia Hospital Association unanimously and strongly recommend that the three Blue Cross-Blue Shield Plans of Georgia at this time effect a merger of their operations, which, in our view, will enable one, strong unified Plan to

"(1) Provide the people of Georgia uniform health care protection;

"(2) Increase the benefits in Blue Cross subscriber contracts;

"(3) Enable all Georgia hospitals to service Blue Cross contracts and be reimbursed therefor in a uniform and simplified manner;

"(4) Improve the reimbursement rate to participating hospitals;

"(5) Cut administrative costs of operating Blue Cross service."

The Blue Cross and Blue Shield Plans involved are: United Hospitals Service Association (Blue Cross) and United Physicians Service, Atlanta; Georgia Hospital Service Association (Blue Cross) and Physicians Service, Columbus, and Hospital Service Association of Savannah (Blue Cross) and Physicians Service Association of Savannah.

NEW DIAGNOSTIC TECHNIQUES MAY CHANGE LABORATORY METHODS—A method for speedy diagnosis of certain communicable diseases has been developed by the federal government, which expects it to lead to "revolutionized" hospital laboratory techniques.

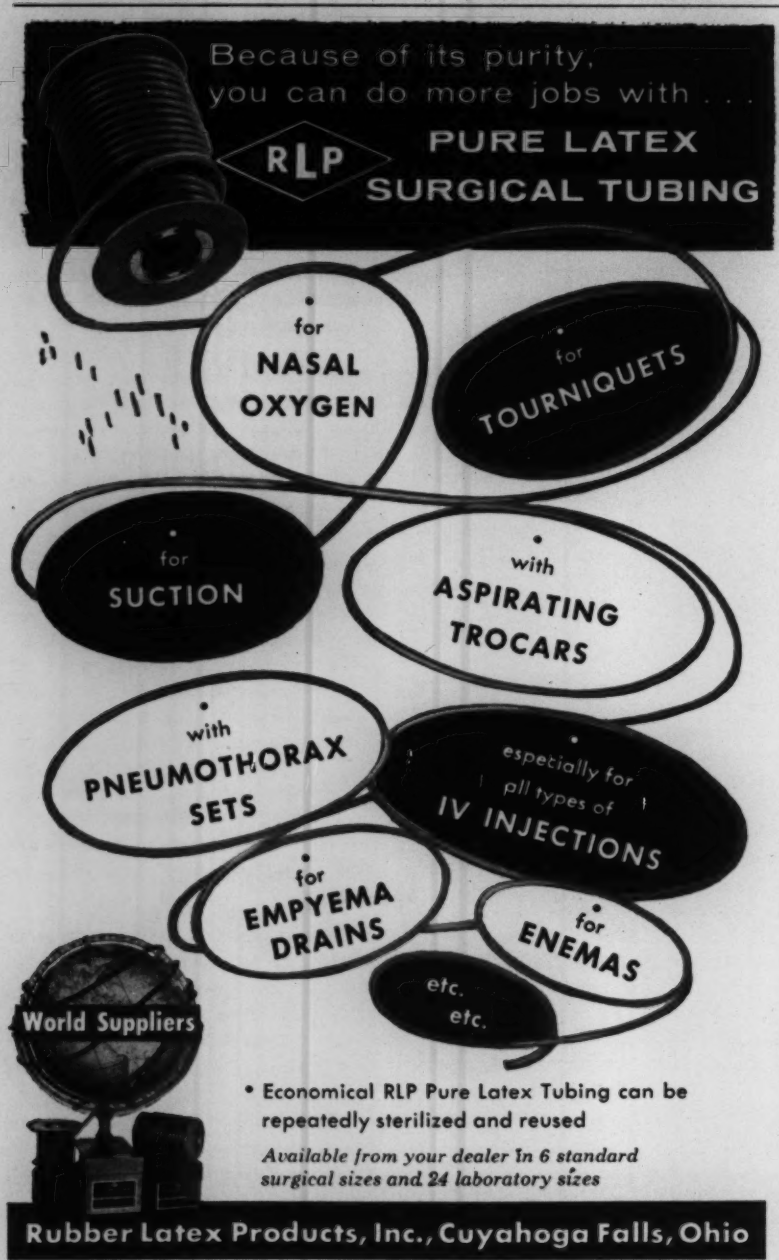
The new method, successfully field-tested in cooperation with the Florida state board of health, is called the fluorescent antibody technique and permits fast slide-testing of specimens.

The fluorescent antibody technique, government researchers believe, will be useful in diagnosing as many as 50 diseases including rabies, diphtheria, poliomyelitis, influenza, typhus, and Rocky Mountain spotted fever. Efforts are being made to adapt the technique for diagnosis of syphilis, gonorrhea, toxoplasmosis, and several other diseases.

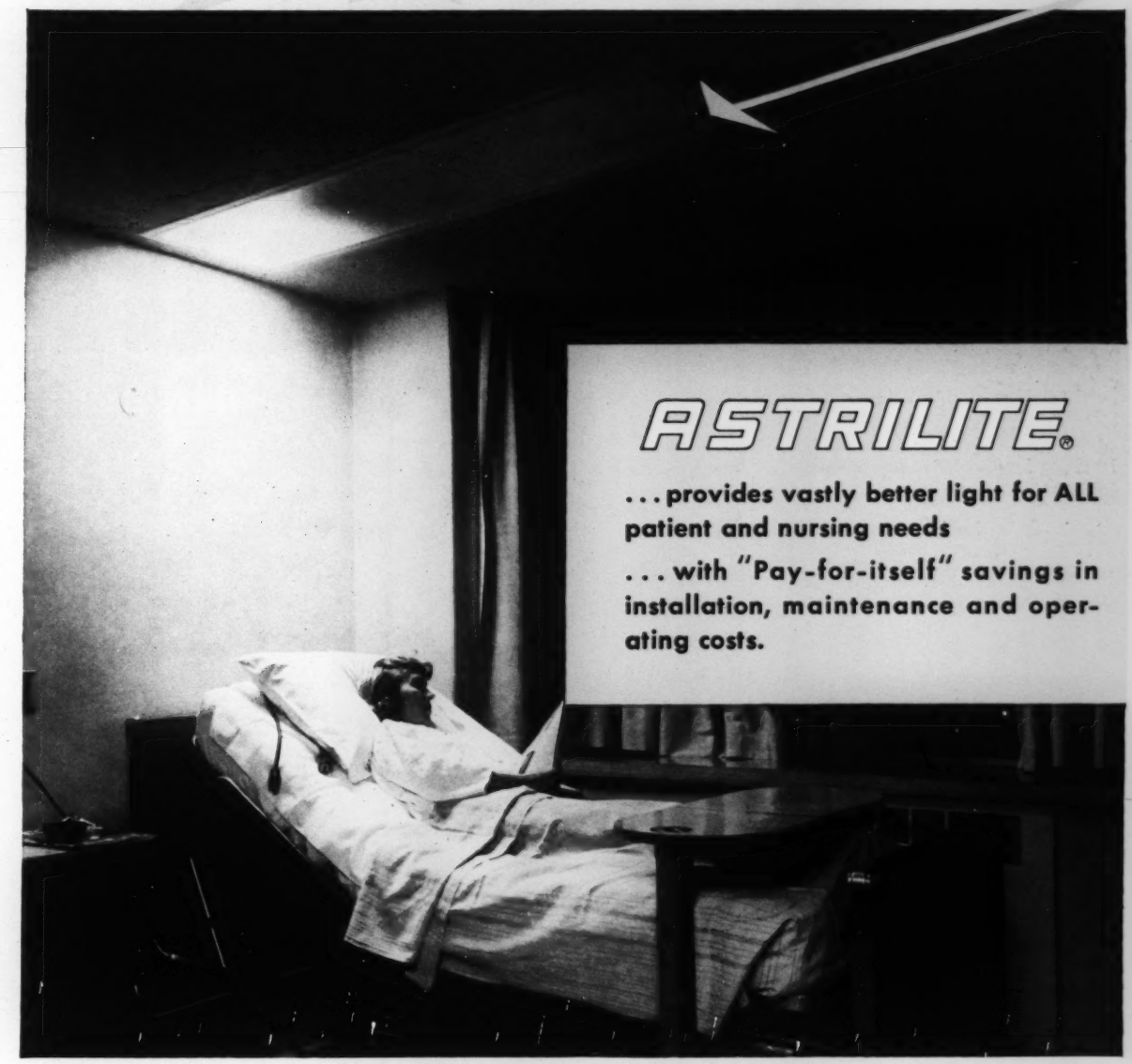
Arthur S. Flemming, secretary of health, education, and welfare, said at a news conference that use of the fluorescent antibody technique might lead to eradication of rheumatic fever and rheumatic heart disease since such disease is preceded by staphylococcal infections, which, with the new technique, can now be detected quickly.

"When testing materials and methods are perfected for the various communicable diseases," Secretary Flemming said, "and when laboratory technicians are trained to use them, the whole system of laboratory procedures for identification of communicable diseases will be revolutionized."

PENNSYLVANIA COMMITTEE RECOMMENDS LOCAL OWNERSHIP OF STATE HOSPITALS—Local ownership of 10 hospitals presently owned by the state of Pennsylvania has been recommended by the Pennsylvania Governor's Committee on Merger of the Departments of Welfare and Public Assistance. According to the Pennsylvania Hospital Association, the committee also suggested that changes should be made in the way state payments are made to hospitals. Details in the April 1 issue of HOSPITALS, J.A.H.A.



—a "Breakthrough" Concept in Hospital Patient Room Lighting


ASTRILITE®
. . . provides vastly better light for ALL patient and nursing needs
. . . with "Pay-for-itself" savings in installation, maintenance and operating costs.

A single decorative ceiling unit provides (1) soft, flattering, general room illumination; (2) comfortable, visually-correct, non-glare light for reading, makeup, etc.; (3) bed-length light of surgical quality for examination, surgical "prep" and nursing care; and (4) safety night light for nursing convenience and patient comfort.

•

This truly revolutionary ceiling unit eliminates the clutter and maintenance of floor, bed, wall and portable lights formerly required in the patient's room.

Even more important, however, ASTRILITE provides diffused fluorescent illumination of comfort and visual qualities vastly superior to harsh incandescents. Because lighting efficiencies per watt are approximately three times greater than incandescents . . . and lamp life as much as ten times longer . . . there are attractive savings in operating and maintenance costs. Designed for flush mounting in new construction or ceiling mounting in existing rooms.

* *Send for illustrated brochure LC-110.*

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NEW FROM SIMMONS

Twosome in Sunny Teak

See what a cheerful glow the new teak finish adds to these two Simmons motorized Vari-Hite beds — to the occasional chair and table, too. Here is the way to add friendliness and charm to a semi-private room, or to *any* patient's room.

The Vari-Hite beds themselves are marvels of utility. A flick of a switch raises or lowers them gently, quietly, safely. The graceful chairs and tables are Simmons Slimline design, hiding the strength and sturdiness of steel under their easy-to-clean finish. And behind the nurse, there's a space-saving Simmons built-in wardrobe — a new addition to the Simmons hospital line.

Simmons hospital furniture brings your hospital the beauty and prestige of topnotch design — and, as always, the almost indestructible durability, quality and ease of maintenance which have made Simmons famous. Styled by Raymond Spilman, A.S.I.D.

Your Simmons agent or nearby Simmons office is always ready with advice based on nation-wide hospital experience.

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service from headquarters

Tool storage and supply

Is there a pamphlet or an article available which provides information on the storage and issue of hospital maintenance tools?

I do not know of a pamphlet or an article that has been published recently on this subject. However, the *Manual of Hospital Maintenance*, published by the American Hospital Association, covers this problem.

In effect, it suggests that all engineering supply tools and equipment should be stored separately from the general hospital stores and preferably convenient to the engineering shops. The manual also suggests that: "Tools for special use, such as electric drills and hammers and portable sump pumps, may be issued to workmen by the maintenance clerk or the engineer, so that a record may be kept of who is using the tools and of their condition on return. Tools may be kept in cabinets for their protection and ease of checking for loss. It is advisable to establish a locked cabinet containing all tools necessary for emergency work at night. These tools should be identified by a distinguishing color and used only for emergencies."

This manual is available from Association headquarters, 840 North Lake Shore Drive, Chicago 11, at $1.50 per copy.

—G. A. WEIDEMIER

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

AHA counseling program

What is the hospital counseling program of the American Hospital Association? Is this service available to all hospitals?

The hospital counseling program of the American Hospital Association, a project sponsored by the Ford Foundation, is available to all governmental and voluntary hospitals in the United States without charge to the hospital, upon request of the administrator.

The program has been designed to assist the individual administrator in the management of the hospital through an examination of organization relationships. The aspects studied include relationships between the administrator, governing body, medical staff and department heads. In addition, the administrative practices of the hospital are audited. Specific areas, such as the business office, nursing department, pharmacy, etc., are reviewed only as they fit into the

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...for better patient care

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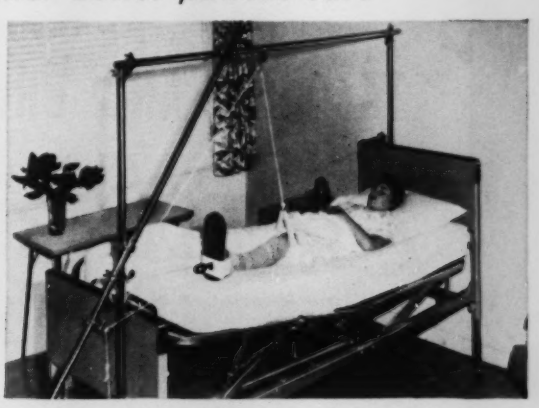

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total management picture of the hospital.

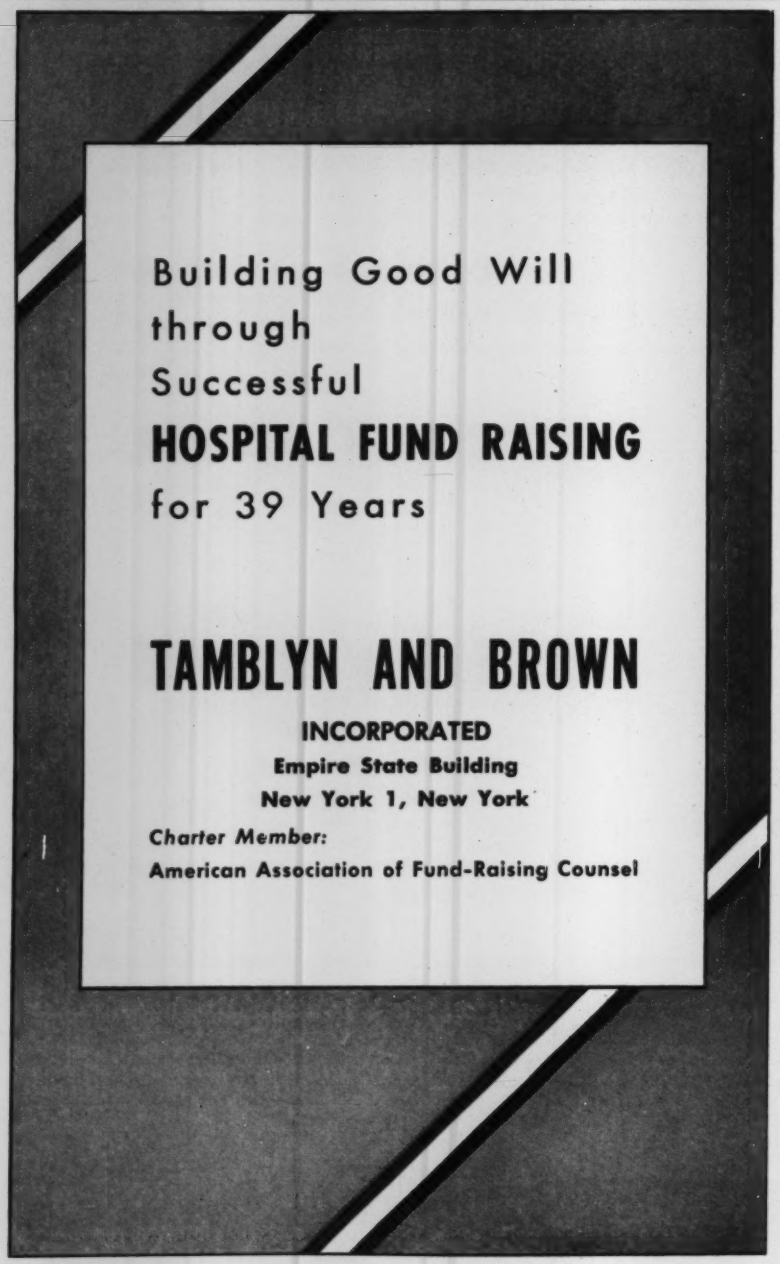
Each survey takes approximately two or three days. Background information about the hospital is secured through a pre-survey questionnaire which is completed prior to the visit by the counseling program staff. The counselors interview the administrator, several members of the governing board, the medical staff, and most of the department heads. In addition to these interviews, the counselors examine various hospital documents and records, such as the hospital's charter; bylaws, rules and regulations of the governing board and the medical staff; and admitting, credit, purchasing and personnel policies and practices.

The results of each survey are then incorporated into a formal report to the administrator outlining the findings and recommendations of the counselors. The material to be included in the formal report is reviewed with the administrator.

Information obtained through this program is kept confidential. The Hospital Counseling Program does, however, retain the right to use any information in its files for research and educational purposes, without identifying the hospital.

Administrators interested in this service should write to the Hospital Counseling Program, American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill.

—WILLIAM T. MIDDLEBROOK JR.



Leasing hospital facilities

Several years ago an article appeared in TRUSTEE that described enabling legislation passed approximately five years ago that permitted the leasing of hospital facilities by municipalities, county and township organizations, to nonprofit organizations. Can you identify this article for me?

The article to which you refer was written by Delbert L. Pugh and appeared in the September 1956 issue of TRUSTEE, the Journal for Hospital Governing Boards. The article also appeared in the Sept. 16, 1956, issue of **HOSPITALS**, J.A.H.A., on pages 44-5. The complete title of the article is "Ohio legislature has passed a bill providing a new method for financing hospital construction."

—HELEN YAST

Designating clinical services

We are planning to use colored name plates on patients' charts to identify the clinical service. Is there any uniform color system designating a specific color for a specific service?

We have heard of a system where red (the color of blood) is used to designate general surgery; yellow (the color of bones) designates orthopedics, etc. Is such a system used generally in hospitals?

Many hospitals use identifying colors in one way or another to designate the various clinical services in the hospital. To the best of our knowledge, however, no particular significance is attached to the assignment of color to any services as a matter of uniformity among hospitals. The decision as to color assignment is generally made by the individual hospital without reference to any particular psychological association.

—HELEN D. MCGUIRE

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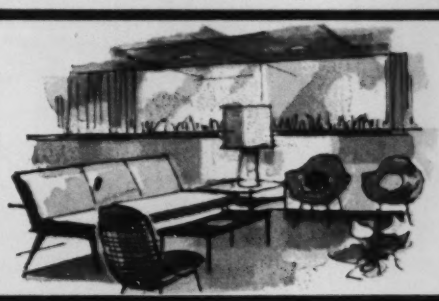

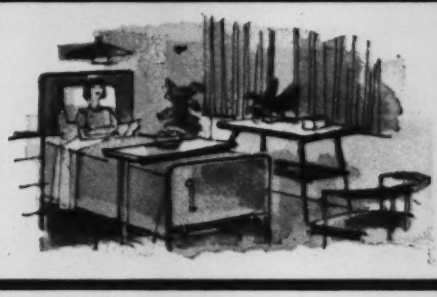

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accreditation problems

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- **Medical order book**
- **Evaluating care in hospitals of less than 25 beds**
- **Evaluating medical care from the chart**

If a medical order book is used by physicians, does the physician have to re-sign the chart once the order is transcribed?

No. If an order book is used by the physician, the physician does not have to re-sign the chart after it is transcribed. The nurse or secretary transcribing orders should sign or initial the order. Hospitals using order books should be sure to keep them as long as is necessary, which means at least for your respective state's statute of limitations.

What, if anything, is being done or can be done to evaluate the quality of care in hospitals of less than 25 beds which are not eligible for accreditation by the Joint Commission?

For the most part, little is being done, although there is strong feeling that something should be done. Fortunately, two state hospital associations have already recognized the need for this kind of work and are embarking on a state program of accreditation for hospitals of less than 25 beds.

How can any surveyor or member of a record committee evaluate quality medical care from a chart?

It is not too difficult and once a pattern has been developed it is fairly easy. As an explanation, here is the way one hospital approached the problem as far as their audit committee was concerned (the audit committee being a combination of the medical record and tissue committee):

1. *Front Sheets.* Are they properly filled out and signed by the attending physician?

a. Diagnoses. Are they adequate to cover the pathology and in acceptable terminology?

b. Progress Notes. Are they sufficient so that clinical course can be followed from the record? The minimum should be daily notes in case of serious illness and at least every two to three days in case of chronic illness. Are laboratory and x-ray reports attached to the chart? Are operative reports in proper order and signed? Are release forms attached if necessary, such as in the case of sterilizations?

c. Was a physical examination accomplished on admission of this patient?

d. Was a history and narrative summary completed on those patients hospitalized?

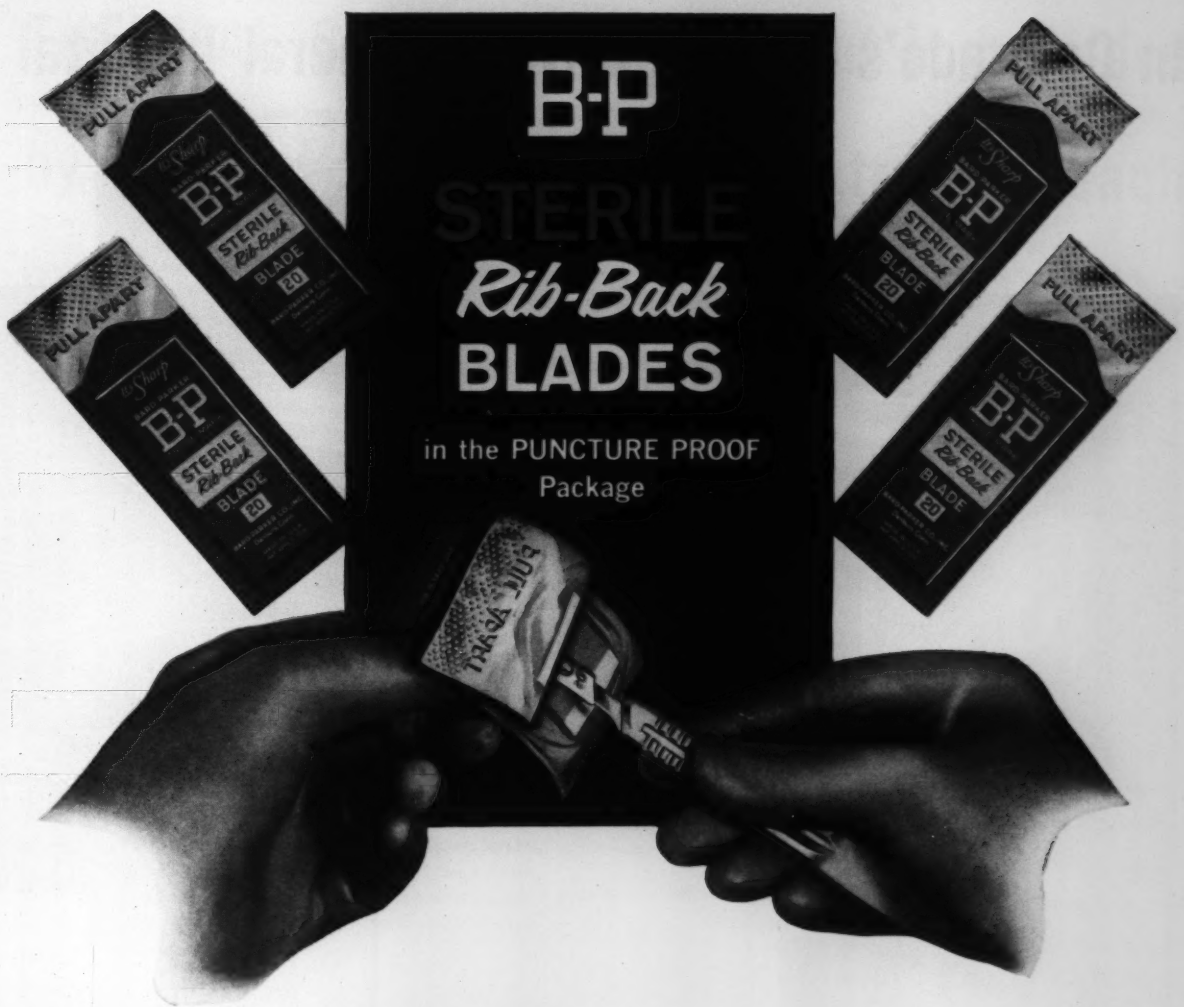
2. *Diagnoses.* Do the clinical findings support the final diagnosis? Do the laboratory findings support the final diagnosis and have they been sufficient in relationship to seriousness of the case? If essential laboratory or x-ray studies have been done on previous admissions or outside of the hospital, have these been noted or properly recorded on the chart? Has a provisional or preoperative diagnosis been made? Is there agreement between final diagnosis and pathological diagnosis, if any?

3. *Treatment.* Was the treatment employed generally acceptable or open to question? Can the method of treatment be judged from the data on the record? Did the physician exceed his privileges?

4. *Results.* Note the final result in relation to the nature of the case and the prognosis. Is it justifiable or not? In cases of death, note whether it is expected, justifiable or not justifiable. Note whether or not there was an autopsy. Were complications justifiable or preventable?

(Continued on page 155)

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 660 N. Rush St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.



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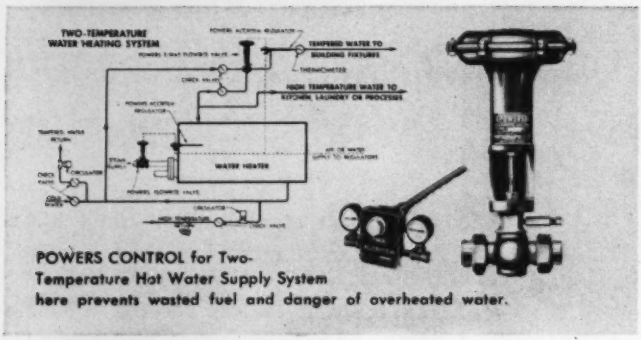
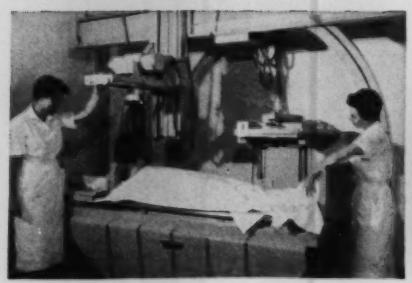
Above: Recovery room for efficient post operative care



POWERS CONTROL for Two-Temperature Hot Water Supply System here prevents wasted fuel and danger of overheated water.

(D8)



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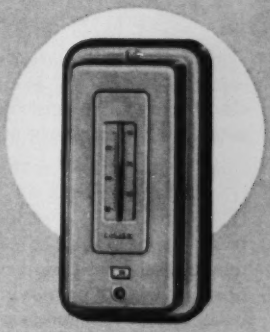

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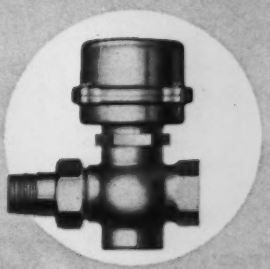

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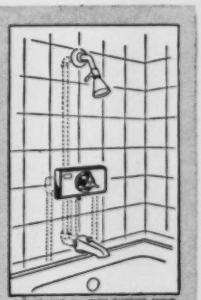

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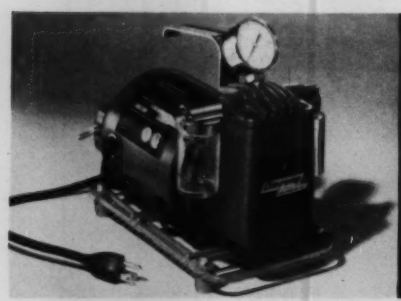
1. Kirkwood, E. S.: Nursing World 129:8, 1955.



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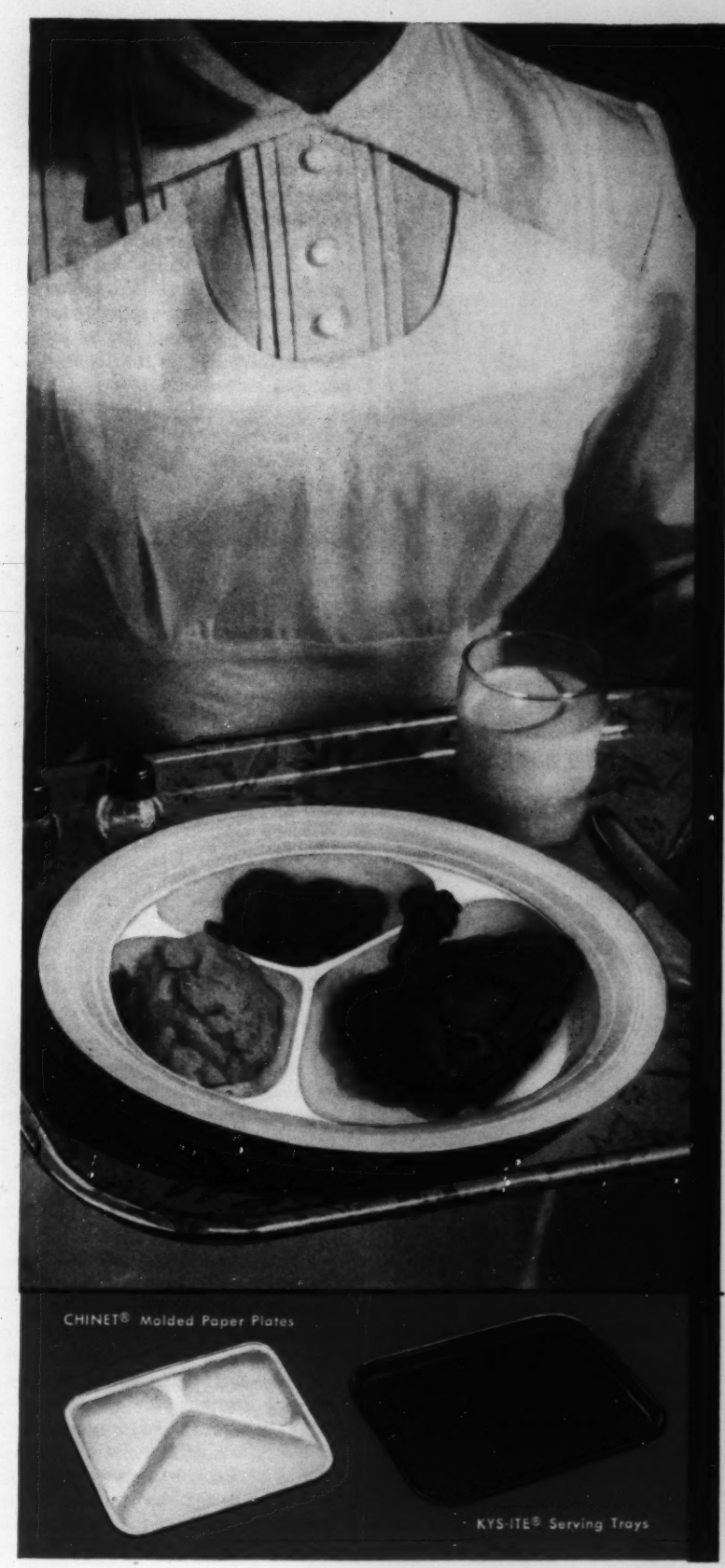

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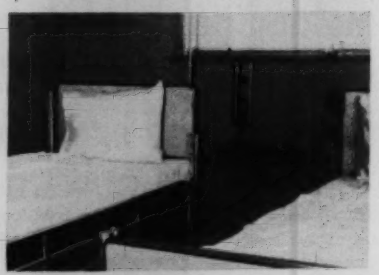

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opinions and ideas

LETTERS TO THE EDITOR

Amendment to news story

Dear Sir:

The item in the "Digest of News" on page 18 of the Feb. 16, 1959, issue of HOSPITALS, J.A.H.A. may possibly be misleading to those not entirely familiar with the situation in Western Pennsylvania where "concession" arrangements for such services as x-ray have never been entered into by radiologists and hospitals. The news item in question read—"In Pennsylvania, three Blue Cross Plans (Hospital Service Plan of Lehigh Valley, Capital Hospital Service, Hospital Service of Western Pennsylvania) agreed to amend their proposals for outpatient coverage so that Blue Shield would not be infringed upon. Outpatient diagnostic services will be paid for by Blue Cross 'only when performed in the hospital and billed by the hospital—not the doctor,' the Plans stated."

The news item might have added: "More important, the amendments were designed to assure that the public, the hospitals and the Blue Cross would not be infringed upon. The amendments were based on a clear understanding that Blue Shield will not cover outpatient diagnostic services provided in a hospital under community agreements. Thus, both nonprofit prepayment plans have agreed that services provided in a hospital under a 'concession' arrangement will not be covered."

In my opinion, a practical solution in the public interest was found to be a difficult problem.—ROBERT M. SIGMOND, *executive director, Hospital Council of Western Pennsylvania.*

The answer is no

Dear Sir:

I think that the title of Mr. Bushnell's article "Are educational standards too high in the paramedical fields?", which appears in the Feb. 1, 1959, issue of the Journal, is seriously misleading and actually not a question properly posed or answered in the article.

Mr. Bushnell's belief that certain elementary tasks in all paramedical fields—for example, dishwashing in the laboratory—should be relegated by skilled personnel to less skilled personnel, is a sound one and widely held. *This has nothing to do with educational standards for the skilled personnel.* In fact, the more supervision of unskilled personnel is required, the better must be the training of the skilled personnel.

The elementary tasks to be delegated should ordinarily not require formal courses, text books, etc. In fact, such "short-term training programs" as Mr. Bushnell advocates, create the real hazard that their graduates may consider themselves as skilled personnel and so represent themselves to hard-pressed hospital personnel directors. On-the-job training of assistants is best suited to meet local requirements.

The answer to the title question, then, is *NO.* My suggested title (perhaps less provoking than Mr. Bushnell's!) is "Should we use assistants to help scarce paramedical personnel?"—ROY N. BARNETT, M.D., *director of laboratories, The Norwalk (Conn.) Hospital.*

[The title on Mr. Bushnell's article was staff prepared.]

Surgical instruments article

Dear Sir:

This is my first experience with a letter to the Editor of a journal or magazine. I venture at this time to express my interest in the article "Surgical Instruments: Serious Gap in National Defense," by John H. Hayes, in the Jan. 1, 1959 issue of HOSPITALS, J.A.H.A.

The author deals with an important subject in a realistic fashion. I do not pretend to know the answer and can add very little to the comprehensive presentation by the author. I am, however, mindful of efforts to secure governmental support for programs of education considered important for the welfare of the nation. Would it not be logical to secure government funds for the training of apprentices in the manufacture of surgical instruments? This step, in

association with others suggested by the author would strengthen the position of manufacturers to maintain what they have, supported by an "artisan bank" for use in time of need beyond immediate stock-piling requirements. The existence of a trained labor force with active as well as government supported standby manufacturing facilities are factors which can mean the difference between strength and weakness in this area of national need.

The critical urgency of an insured supply of surgical instruments to meet regular and extraordinary requirements cannot be overstated.—M. HINENBURG, M.D., *Federation of Jewish Philanthropies of New York.*

Prepayment and progress

Dear Sir:

I have read with interest the discussion between Mr. Bubee and Dr. Crosby in the January 1 issue of the Journal. It is marvelous to me to have seen the great advancement we have made socially because of the voluntary hospital prepayment plans and, in addition, the contributions of the insurance companies. To me it seems it would be utterly impossible for hospitals to have acquired the wonderful equipment that they possess today, without these nonprofit prepayment plans and the insurance companies.

When Mr. Bugbee speaks of costs in the last paragraph of the article, I assume he is talking of the costs to the patient, or the billed charges, as certainly the actual cost to the hospital would by no stretch of the imagination be related to the insurance and nonprofit plans, but, on the contrary, if these plans were not in existence it would be impossible for the public to meet the charges which hospitals would necessarily have to make. After watching the trend for 30 years, I feel that hospitals have kept pace with other advancements in our social system and have never put any additional charge on the patient's bill because of the existence of insurance. Hospital rates and charges are always fixed in advance and entirely separate from billings to the patient. —R. L. LOY, *administrator, Mercy Hospital, Oklahoma City.*

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When injected, heparin's *natural* action in the body is to prevent the conversion of prothrombin to thrombin (antithrombin action). By neutralizing thromboplastin, it also acts as an anti-prothrombin. Further, it inhibits the agglutination and deposition of platelets, thereby discouraging thrombus formation. Heparin acts directly on blood clotting constituents and does not destroy any component of blood or permanently change the normal constituents of blood. For emergency use it is the *only* anticoagulant which acts almost immediately (within a few minutes on intravenous injection). For safety's sake, its action can be terminated rapidly when necessary. Because of its rapid action, most authorities agree that initial control of thrombo-embolic diseases should be effected by means of heparin administration.

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Regulation of Anticoagulant Action	Easy	Difficult
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Liquaemin Sodium can be obtained in a variety of dosage forms and strengths, from the original low concentration of 1,000 U.S.P. Units (approx. 10 mg.) per cc for continuous intravenous drip, to the 20,000 U.S.P. Units (approx. 200 mg.) per cc in gelatin, to the 20,000 U.S.P. Units (approx. 200 mg.) per cc aqueous solution for convenient intramuscular depot anticoagulant effect. With its 20,000 U.S.P. Unit per cc aqueous solution of Liquaemin, Organon pioneered the now widely accepted concept that prolonged heparin effect can be achieved by injecting intramuscularly an *aqueous* solution of high concentration-low volume heparin.

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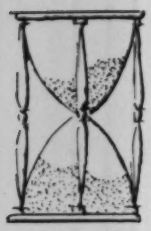

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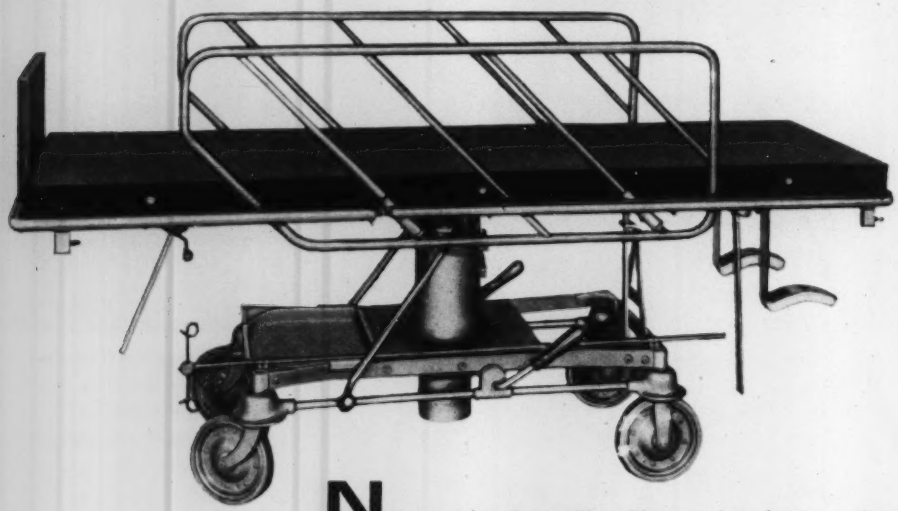

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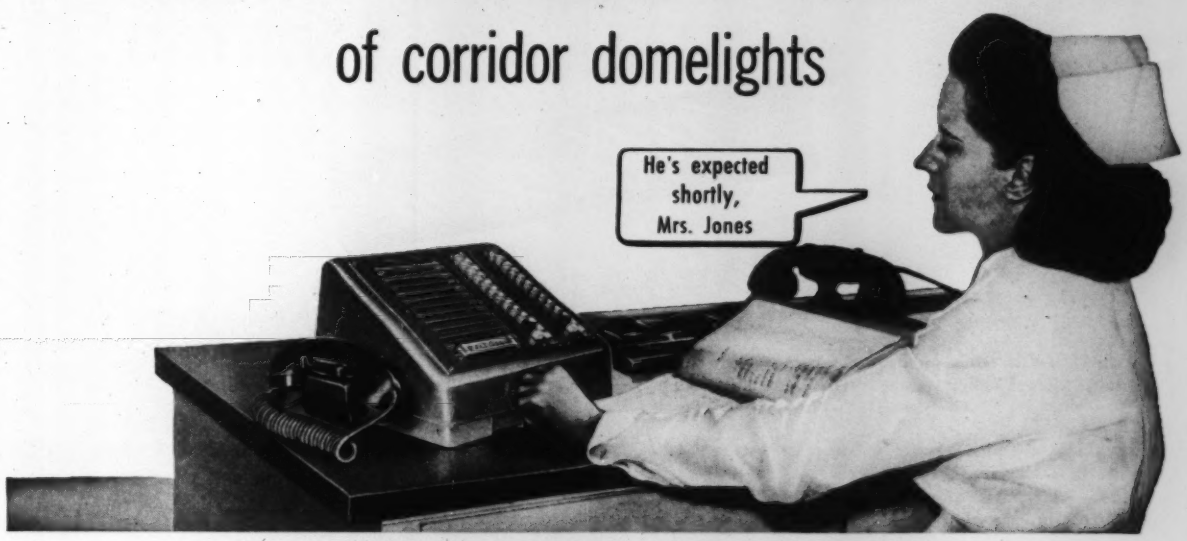

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1. Grossman, L.: *Archives of Pediatrics, 71: 173—179, June 1954.*

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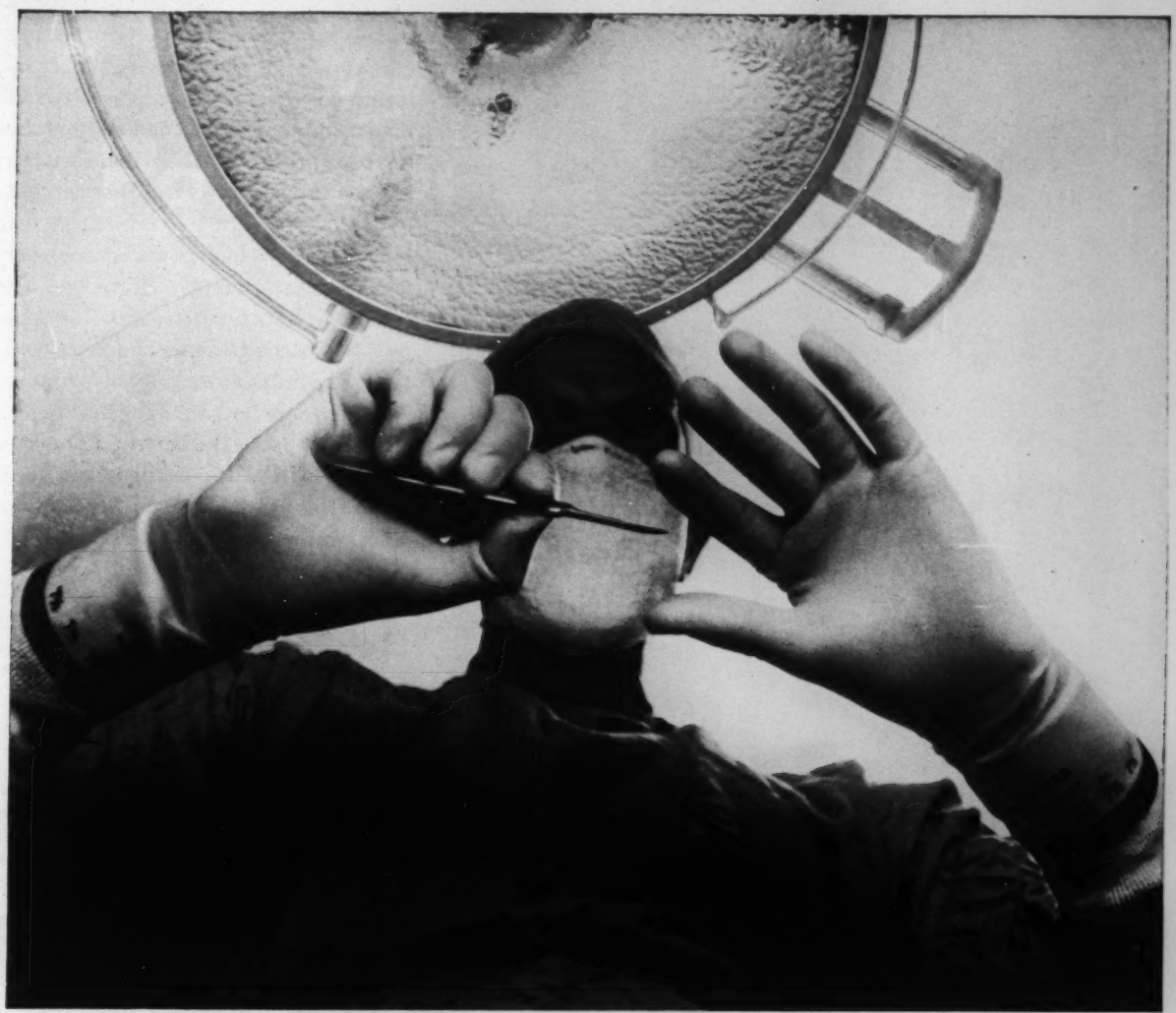

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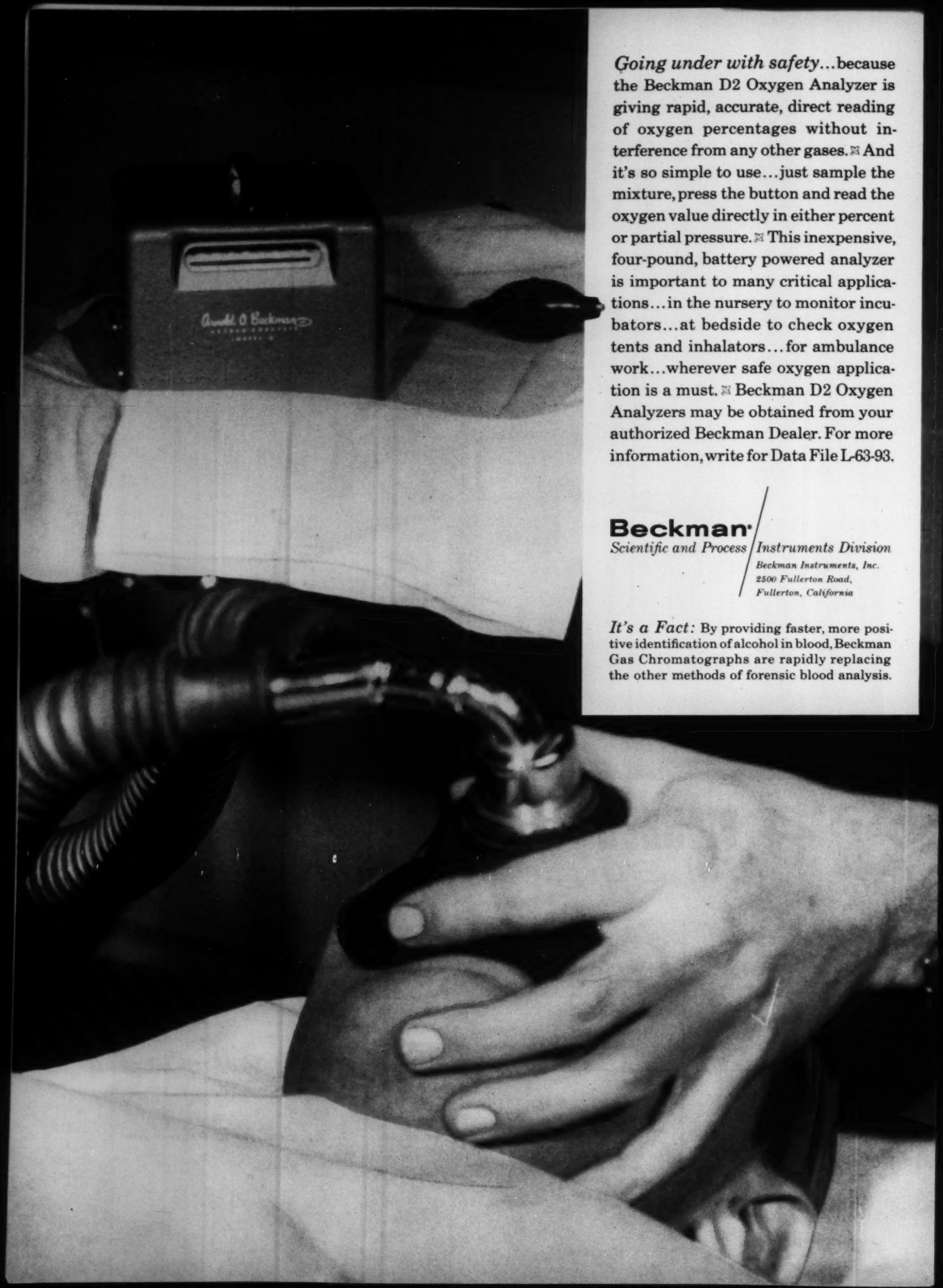

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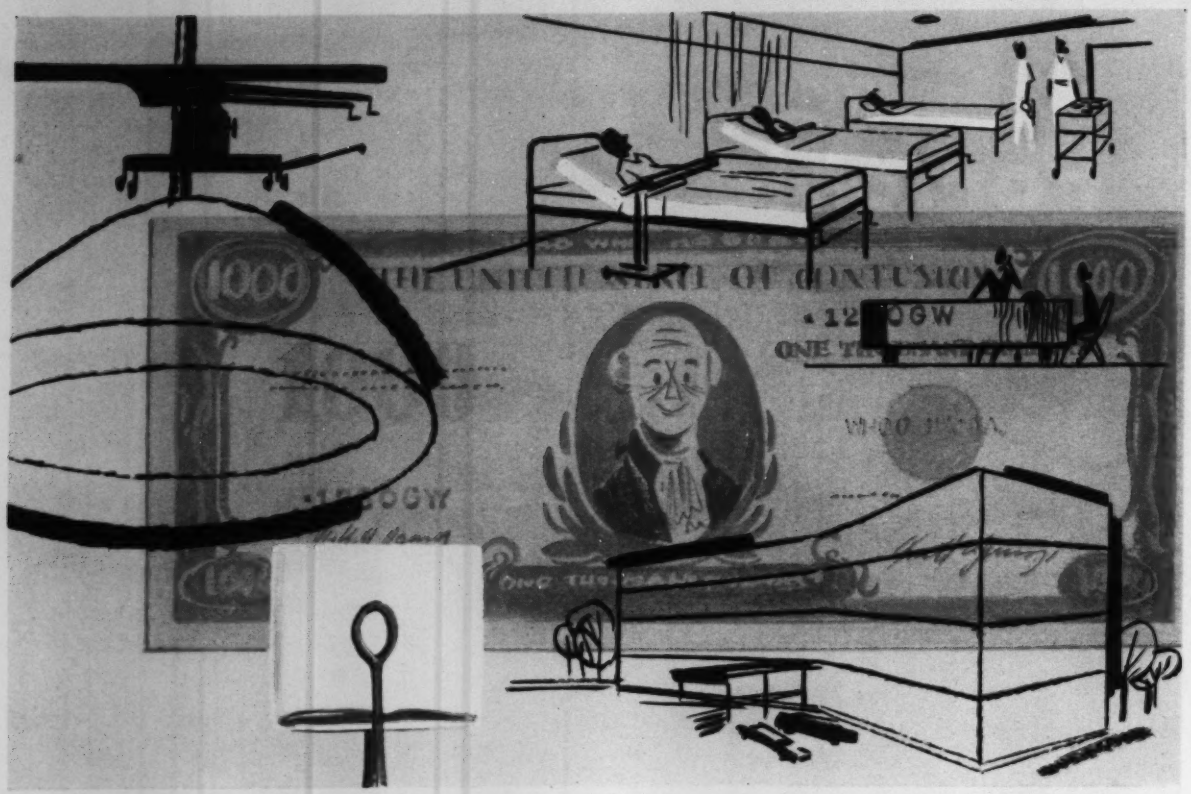

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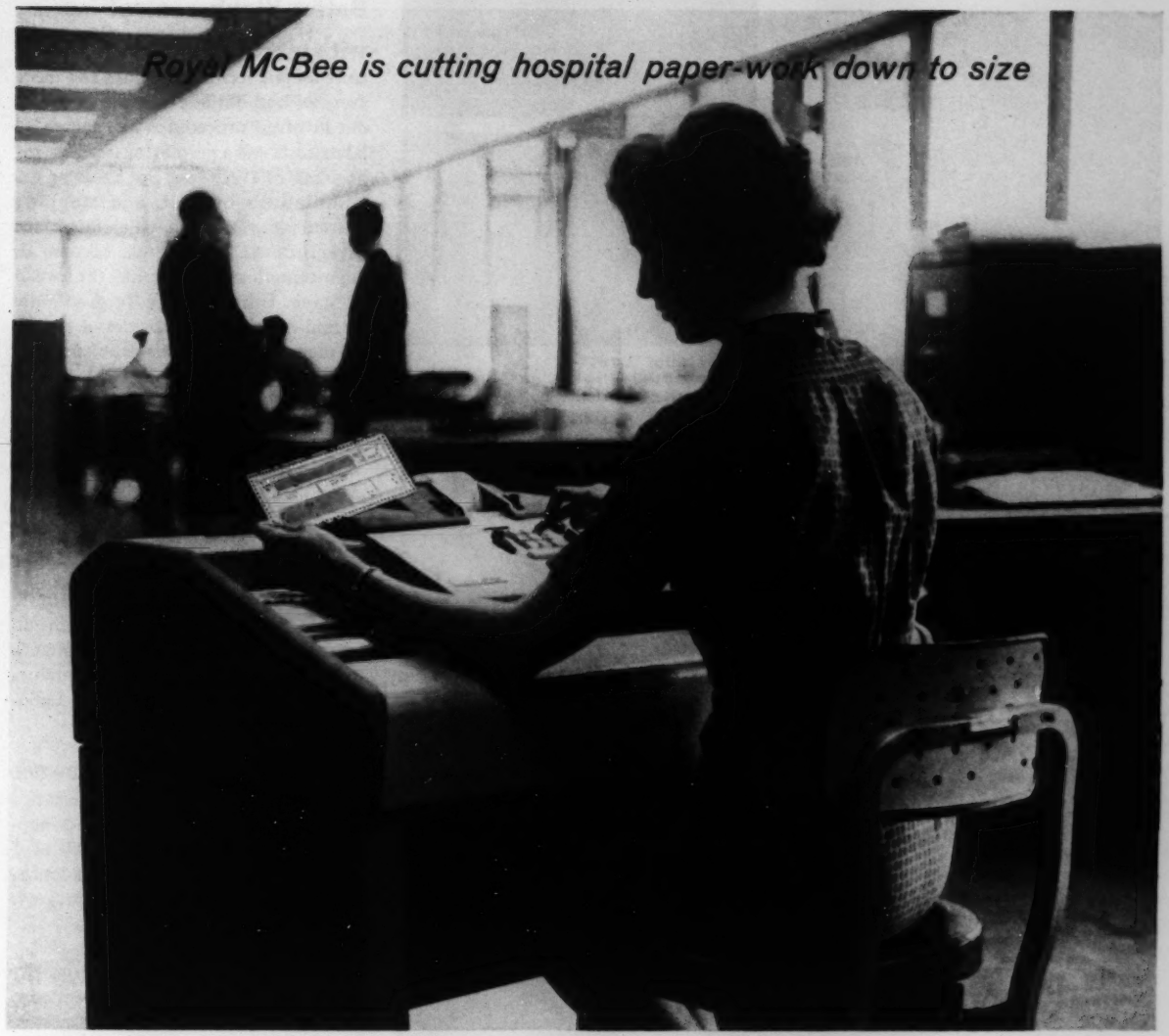

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How Tergisyl DETERGENT-DISINFECTANT fights Staph infection yet cuts labor costs as much as 47%

Time studies under actual hospital conditions *

Cuts labor cost 47%
(by mop-and-pail method)

Comparative time studies of Tergisyl vs. conventional method of washing and disinfecting using mop-and-pail technics reveal that one-step Tergisyl method reduces the man-time required by 47%. Actual time saved was 25 minutes per 1,000 square feet of floor area — a labor saving of 125 man hours or 15 man days per week in a 300-bed hospital.

Cuts labor cost 22%
(by machine scrubbing-vacuum method)

Comparative studies of Tergisyl vs. conventional machine scrubbing-vacuum pickup, followed by mop-and-pail application of disinfectant, reveal that one-step Tergisyl method reduces the man-time required by 22%. Actual time saved was 23 minutes per 1,000 square feet of floor area — a labor saving of 20 man hours or 2½ man days each week in areas of heavy soil in a 300-bed hospital.

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Comparison of cleaning and disinfecting efficiency of Tergisyl vs. conventional method showed greater cleaning ability for Tergisyl than the detergent previously judged acceptable by the hospital. "Before" and "after" bacteriological tests confirm Tergisyl's bactericidal, fungicidal, and tuberculocidal efficiency.

* *Details available on request.*

Better Staph control with less effort

How to apply truly aseptic technics to more and more areas of hospital housekeeping — without involved procedures and increased labor costs—is a perplexing problem for hospitals of every size. But avoiding accumulations of dust, and stopping movements of dust on which infectious organisms can "travel," has become an important *must* in preventing the spread of Staph. Lehn & Fink's Tergisyl™ detergent-disinfectant provides a practical means of solving this problem.

"Infection" Committee Frequent and thorough use of Tergisyl, with known bactericidal, fungicidal and tuberculocidal activity, can do a great deal towards eliminating air-borne bacteria and cutting Staph infection to a minimum.

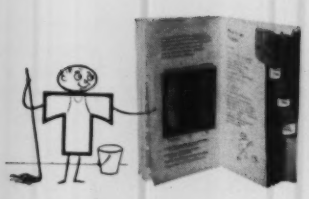
Surgical Staff and O.R. Best defense against Staph is careful attention to complete environmental asepsis, including floors. Tergisyl is safe for conductive floors and is Underwriters' Laboratories approved.

Administrator For every 100,000 square feet of floor space now cleaned and then disinfected by man-and-mop-and-pail, you can save as much as 5 man days per week, or 40 man hours, by adopting the one-step Tergisyl method.

Housekeeper Complete twice the work in half the time—and save money on both labor and materials. One-step Tergisyl cleaning—which includes dependable disinfection — requires little instruction. No rinsing needed.

Purchasing Agent By standardizing on Tergisyl™ detergent-disinfectant you will cut costs of cleaning and disinfecting supplies and simplify inventory control.

Best test of Tergisyl's labor-saving advantages is use in your own hospital. Please try it. We will be glad to help you with any infection problem you have. Technical assistance is available to your Committee on Cross Infection or to individual department heads on request. Just write:



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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—*quality, not quantity*

The Hospital Survey and Construction Act (Hill-Burton Program) over the past 12 years has succeeded in filling an important gap in the health care of the nation by financing, in part, the construction of hospitals in communities where medical care was admittedly inadequate. Today, the problem that faces the nation is not how to fill the gaps of health care, but rather, where to establish centers for health care so that skilled personnel can be used most effectively to serve people requiring such care.

Recognizing this new trend in the provision of health facilities and services, the trustees of the American Hospital Association approved, at their Nov. 21, 1958, meeting, a statement in regard to hospital construction in small communities.

It points out that "some small communities in their enthusiasm for a hospital have provided or are planning to construct a new hospital in a location which is not in the best public interest. The desire to provide a hospital to attract a physician to the community or to retain a physician is frequently given as the primary reason for initiating hospital planning activities. The belief that a hospital will improve the economic status of a community is highly overrated. Competition with nearby towns, community pride and reluctance to travel are factors which are frequently invoked. Usually the emphasis on the number of beds rather than on the quality of services to be provided, and the importance of being able to secure and retain a competent hospital staff is frequently overlooked."

The statement goes on to describe what hospital care comprises today and points out what realistic hospital planning really means. If the health dollar is to be used effectively and economically, sound planning is the key through which this goal will be achieved. The people of this country are fortunate in the high quality of health care that has become so abundantly available. If it is to be kept available, health skills, resources and facilities will continue to require the sound planning that has been the hallmark of the Hill-Burton program.

OFFICIAL NOTES

Actions taken by the Board of Trustees of the American Hospital Association at its meeting in Chicago, February 3, are reported in this issue in the Association Section on page 72.

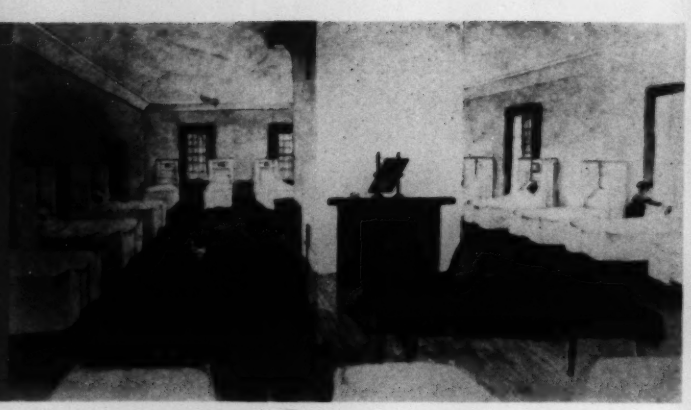
—*two things at once*

Hospitals, like humans, have personalities, traits and traditions. They also have reputations, which largely determine their effectiveness.

There is no quarrel here with the dictum that the best way to obtain a good reputation is to deserve it. But for a hospital, this can be a misleading simplification. A hospital's reputation rests not only on the big things it does but also on the little things it doesn't do. Its reputation can be no better —or worse—than the impressions it conveys to the community it serves. Impressions, however, are often fabricated from both the trivial and the vital; from the way a hospital looks, for example, as well as the way it cares for patients.

Both of these factors, of course, should be carefully considered in designing or remodeling a hospital. It is good if a hospital is functional but it is even better if it is also attractive. Fortunately, function and beauty are not mutually exclusive. The special planning and construction section in this issue underlines this point. The articles and illustrations in it have been selected to show that it is possible to do both of these things at once, and be practical about them.

SPECIAL SECTION ON PLANNING AND CONSTRUCTION



WARD at Massachusetts General Hospital in the 19th century contrasts sharply with one-bed room at Memorial Hospital, Long Beach, Calif., depicted on opposite page in an artists' drawing.

Professional interior design is a good investment for a hospital, states the author. In outlining reasons for his opinion, the author discusses psychological and financial advantages of a warm and comfortable atmosphere in a hospital. He also lists "specifications" that can help administrators in selecting design firms, and provides a check list of items and services the chosen firm should provide.

THIS ROOM *has warmth. It seems friendly, inviting.*"

"I like the colors here. They show good taste."

These and similar reactions have probably been heard by hospital people with increasing frequency in recent years. Americans have developed, to an unprecedented degree, a sensitivity to arrangement, appearance, and atmosphere.

This appeal to the eye and the mind is something hospital administrators should not overlook. The public certainly has not overlooked it. In increasing numbers, people purchase well-designed automobiles, shop at ultra-modern supermarkets, and patronize hotels which have been constructed or remodeled to meet the newest standards of eye appeal. Even banks and office buildings have discovered that it pays to have excellent interior design work done. I believe it can prove a good investment, too, in a hospital.

'PLUS' FOR PATIENTS

Few people want to go to a hospital. This feeling of reluctance can be accentuated if the hospital plant is cold, drab, and depressing.

We are constantly striving to reassure patients, to give them a feeling of well being, and to replace their sense of despair with optimism and hope. I have been surprised to note how helpful the proper use of color, the wise choice of fabrics and skillful arrangements of furnishings can be in creating a feeling of reassurance in patients from the moment they enter a hospital. This "plus" for patients, however, is not the only value derived from creating a warm and comfortable atmosphere in a hospital.

It can pay in dollars and cents, too.

It has been my experience in hospital projects involving an expenditure of some $15 million that the investment made in professional services in this area is returned many times in savings on initial purchases plus the long-term economy of lower cost maintenance of properly selected interiors.

BEWARE OF MAJOR PITFALL

We must be certain at the outset that we do not stumble into a major pitfall. Specifically, we must not make the mistake of thinking that "functionalism," which is given us by the architect, is the same as "interior designing," which is a highly important and supplementary service.

A hospital can be exceptionally well-planned from the functional point of view, and yet seem almost ugly and depressing to all who use or benefit from its highly efficient work areas. Now, this is not an argument against good functional planning, when we are never really satisfied with even the best. It is, however, intended to focus attention on the fact that excellent interior design is not only compatible with the smoothest work flow pattern, but should be considered as a necessity that effectively, efficiently, and economically supports the functional plan.

There may be a serious, widening gap between the completed work of the hospital architect and the actual operation of many areas of the hospital. While this gap is not so apparent in the operating room, x-ray department or laundry, it may be quite obvious in the public areas, and of real concern in the nursing units.

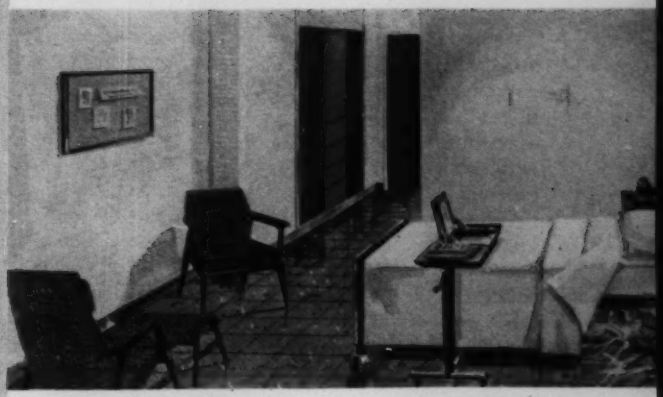
I refer to the pressing need to ease the mind of the patient as well as to meet his physical problems; to reassure him from the moment he steps in the front door; and to have him *see* for himself that the hospital cares about him and his interests.

The architect strives to achieve this goal in the very design of the building. Administrative people

Donald C. Carner is administrator, Seaside Memorial Hospital, Long Beach, Calif.

FUNCTION PLUS— *IS WHAT THE PATIENT WANTS*

by DONALD C. CARNER



attempt to accomplish the same objective in their selection of furniture, draperies and related items. As in other fields, however, there has been such a tremendous increase in the almost daily changes of the thousands of articles and materials which can be considered for hospital use.

Highly specialized knowledge is required to cope with problems of interior space, planning, lighting, mill work and cabinet details. In addition, color, fabrics, furniture, floor and wall coverings are essential considerations that require the participation of experts. We are becoming increasingly aware of fine paintings and sculpture as a humanizing influence on our interiors. All interior items should not be procured haphazardly but should be carefully integrated into a harmonious, effective, economic unity.

PUBLIC AREAS IMPORTANT

It seems to me that, in general, hospitals do a reasonably acceptable job of carrying out this concept in most work areas—surgery, for example. Hospital planners know this area well. They are knowledgeable regarding floor space requirements, lighting, air conditioning, operating room equipment, and the like. This knowledge, however, is not always brought to bear in public areas where the patients and their visitors may be more inclined to judge the atmosphere of a hospital.

The handling of such areas as cafeterias, snack bars, lounges, offices, and waiting rooms affects the attitude of people toward the hospital. The able administrator is aware of this fact and realizes that only the more gifted individual can deal effectively with the intricacies of such problems as specialized lighting, color coordination, etc. How, then does one meet this problem effectively and economically?

At least two courses of action are available. It is important to make an analysis of all the factors related to the particular hospital under consideration before reaching a decision on which course is best.

Varying degrees of assistance may be obtainable from manufacturers and distributors. Producers of paint, office equipment, furnishings, and furniture frequently have decorators on their staff for the primary purpose of making their services available to customers.

Merchandising firms often take considerable pride in the caliber of advice they are able to offer hospitals. Such organizations may be local, regional, or national in scope. Usually no direct charge is made for the services of these people. It is, of course, apparent that the dispenser of the service must obtain some sales income to carry the expense inherent in offering the decorators' time and talent. This income may be gained by way of commissions or mark-up on the cost of goods sold.

Personal inspection of the work done for other customers, and a close check of reference is advisable. Some assurance should be obtained regarding the stability of the organization so that the work will not be unduly delayed by illness, change in personnel, or other factors.

A second approach is to obtain the services of a competent professional interior designer or design firm. Architects often provide this service for an additional fee. Where they do not offer the service, architects may encourage their clients to retain competent professional advice. This may pose a real problem, however, as today almost anyone may decide overnight that he or she is a fully qualified interior designer.

THINGS TO CONSIDER

As a guide to selection, I would suggest that consideration be given to developing what might, for lack of a better term, be called "specifications." Here is an outline of factors which might be of help in assessing various professional designs:

1. Is the firm well-established and unquestionably successful? Does it have a record of repeat business?

2. Does it have experience in a

variety of interior design situations covering many of these categories:

CAFETERIA
SNACK BAR
OFFICE BUILDING
HOTEL
GIFT SHOP
DRUG STORE
CHAPEL
LAUNDRY
LIBRARY
EDUCATIONAL FACILITY
SCIENTIFIC LABORATORY

3. Is continuity of service assured? The firm should be able to give complete assurance that, once underway, the project will be completed on schedule with no interruption tolerated (because of illness, other business, vacations, death, etc.). Availability for future consultation is desirable.

4. Does the firm use a professional and ethical approach with entire compensation based solely on a fee for services? (No commission, mark-up, cut, "kick-back," etc.)

5. Does the organization include architects and draftsmen, competent decorators, designers, and specification writers?

The finished "product" of the consultant would, in most cases, include scale drawings of plans, elevations as well as details, special lighting, mill work, cabinet work, etc. Either the drawings or specifications or both should include paint or wall covering selections, drapery fabrics, upholstery materials, floor coverings, etc. Most importantly, these drawings and specifications must be of an exactness, quality and caliber that will permit accurate cost estimates, as well as equitable competitive bidding. This is essential to the total economy of the project.

6. Is the firm qualified to analyze work flow and methods, so that office furniture and equipment selection, as well as layout and space utilization, will provide optimum working conditions?

I would also suggest the development of a guide toward a fuller understanding of the scope of the work and the responsibilities of the hospital, as well as of those of the interior design firm or other consultants.

Interior design people say, and I would agree, that whenever the services of an interior designer are retained at an early stage of a project, the greater has been their effectiveness. The earlier the development of a team concept among the architects, engineers, interior designer and the hospital, the more fruitful the relationship. The interior designer may be brought in at a later stage, however, well after the architects and engineers have performed a major portion of their work, and most of their plans are already prepared. Even at such a point, an interior designer's effectiveness may well constitute a major contribution.

At whatever point the interior designers are introduced into the project, their fundamental function should be the integration of all interior components, to aid in attaining the hospital's basic objectives. The interior designer's role is to achieve unity and serenity of all the interior components, while maintaining or improving the functional and efficient elements that are essential to the hospital.

WHAT A DESIGNER SHOULD DO

The following points constitute the beginning of an informal check list of the items one should require of an interior designer:

1. Submit color schedules for all interior painting and decoration, floor covering, tile, marble, and terrazzo.

2. Submit layouts of furniture. Indicate positions on floor plans.

3. Select and specify for competitive bidding furniture, carpeting and furnishings. Prepare furniture and furnishings schedules and catalogues.

4. Consult with the hospital and architect on modifications or changes on interiors, as possible improvements may suggest themselves during the progress of work.

5. Assist in supervising, expediting and purchasing as may be required.

6. Submit analysis and recommendations of all bids.

7. Prepare and submit budget estimates prior to the call for bids.

8. Begin and complete consulting work on prearranged dates.

9. Receive payment as work progresses, in a specified number of equal monthly installments.

10. Expenses, other than fees, require prior approval of administrator.

11. A specific member of the decorating firm assigned to head the project. All work must be personally reviewed by the principal.

12. The total sum expended for furniture and furnishings may not exceed a sum as agreed upon in advance.

FEES AND ETHICS

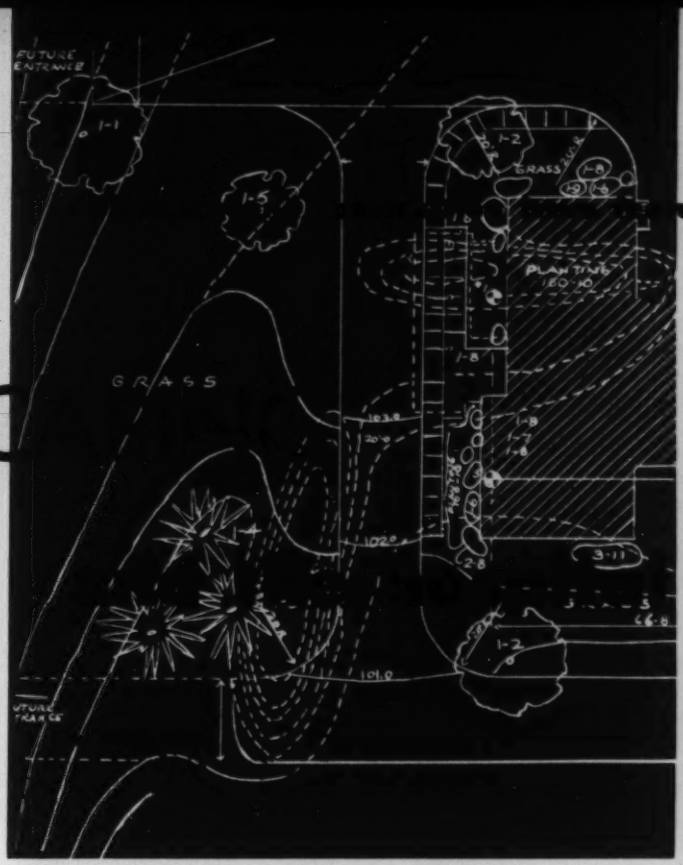
Many professional interior design firms prefer to work on an hourly fee basis. They may consider it unethical to be compensated by commission. Many firms consider any arrangement of this type as interfering with the objective standard they desire to maintain in the client's interest.

Highly favorable public reaction is the result and reward of this effort to actively and visually demonstrate an interest in the patient. A vast store of information and experience is available to hospitals, to make the hospital appealing, interesting and quietly reassuring to the patient through its clean, orderly, attractive appearance. It is possible that hospitals may be considered remiss in their responsibilities unless a determined effort is made to close the gap existing between the basic architectural design of the structure and the purchase of furnishings, furniture and equipment.

Just as the interior designer's work will augment the architect's concepts within the building, so will the work of a qualified landscape architect make a valuable contribution in helping attain a pleasing, restful "setting" for the building.

Leaders of industry and commerce have demonstrated the hard-headed business value of achieving complete unity in function, landscaping, and interior design as an aid in attracting and retaining better employees, as well as creating the most effective visual appeal for their clients. In the hospital field we have these most desirable goals, plus the even more basic objective of reassuring our patients and helping them achieve a feeling of well being from the first moment they turn to the hospital for care. ■

LANDSC



Plants, grass and trees, the author contends, not only help "humanize" hospitals but also have a fundamental function in recuperation of convalescent patients. The author lists various types of plants, explaining the purposes of each. He also discusses factors affecting the durability of plants and costs of landscaping.

GREEN GRASS, green trees and flowers are aesthetic "vitamins," much needed to counterbalance the pressure and tensions of daily life. The human make-up, as a whole, is less sophisticated than we recognize, and remains closely connected with the beauty of nature. The 36 million people in the United States who visited national parks last year to absorb the beauty of these primitive areas bear witness to this fact.

Landscaped areas surrounding hospitals, sanitariums, and similar institutions, not only give the building a pleasant and harmonious setting, but they also have a fundamental function in the recuperation and rebuilding of health and spirit of the convalescent patient. The cascading bloom of a shrub, a twisted branch of a tree, an old-fashioned flower pot filled with geraniums, an abundance of ever-blooming petunias, chrysanthemum in all of the hues of fall colors, or just green grass all have healing powers for both body and soul.

The design of hospital areas such as gardens, courtyards, or intimate clearings is fundamentally related to their needs and purposes. For example, a playground for physically handicapped children should include elements to stimulate the imagination of the children and provide entertainment, whereas an outdoor area to be used for relaxation by adult convalescent patients should be a thing of beauty. A recreational space for nurses, in a cosmopolitan area, might be in the form of a roof garden. For sisters of a Catholic hospital, an intimate garden for meditation would be appropriate.

Franz Lipp, Chicago, is a landscape architect.

PLANTS AND THEIR PURPOSES

An indoor garden or solarium is also important as a social gathering place for patients and their visitors. Quite a number of plants are usable for these green gardens as they last for a number of years and grow into beautiful specimens. Blooming plants, of course, provide color but have to be replaced more frequently. A number of new varieties of rubber trees with large dark-green shiny leaves, such as Ficus elastica decora elegantissima (what a wonderful name), and variegated dark-green and grey-green trees of the same species will grow to formidable size.

In addition there are other satisfactory plants, such as Schefflera, Aucuba (the old-fashioned European butcher plant which can be found in almost every butcher shop of Germany and Holland), Phelodendron obtusa and many other varieties of Phelodendron. Other dependables which are almost everlasting are the ornamental Crassula and Tomeia, the "piggy backs" which propagate easily.

Then there are the plants usable for groundcover, such as Tradescantia, Wandering Jew in many variegated forms, the ornamental striped Pepperonias (a native of Florida), and Cissus, a grape ivy which is also a wonderful climber and will cover whole walls.

For accents, Dracineas and colorful Caladium are available—intriguing in foliage and design, some large, some bizarre and elegant.

Boxwood will do reasonably well, if the greenhouse is kept on the cool side.

Cinnamon plants—for fragrance—are easy to grow. It's a never failing delight for a visitor to discover the wonderful fragrance of a cinnamon plant by rubbing its leaves. Lemon Geranium, Rose Geranium and Heliotrope are also old-fashioned favorites for the

nose. They date back to the herb and cloister gardens of the middle ages.

A great many varieties of Cacti will do very well in a sunny, dry, hot solarium. They often will bloom.

In addition, there are a number of annuals and biannuals such as Nasturtiums, Snapdragons, Stocks, Violets, Geraniums, Coleus and Dianthus; and bulbs such as Daffodils, Narcissus, Crocuses, Tulips, Hyacinthus, Amaryllis and Tuberus Begonias, which will provide a variety of color in a solarium during the winter months and are easy to raise.

DURABILITY AND COST

The following are some of the basic factors which determine both the initial and maintenance costs of landscape installation:

- Whatever the function of an area may be, the basic requirement is simplicity of design. This factor is closely related to minimum cost of maintenance.
- Another basic key to a successful planting is the careful selection of plant materials. This depends in part on soil and climatic conditions of the project. Also, certain plant forms of a species develop every qualification of a top quality plant—offering beauty, durability and minimum maintenance requirements such as watering, spraying and pruning. Other varieties of the same group may be poor growers, attacked by plant diseases and not worth the financial investment and the space and soil they take up.
- Consideration should also be given to plant growth in relation to the building and surrounding space. It is of vital importance whether a plant will outgrow or maintain its proportions. The structure of the root system determines whether a plant group will choke itself out in time or develop into profuse planting masses.
- When trees and shrubs are transplanted, a fiber root system will simplify, and a tap root system will complicate, this operation. Trees which are difficult to transplant in a large size may be successful when chosen in a smaller size. It is simply a technical question from the standpoint of design whether a plant of smaller size can be used to achieve the ultimate desired effect or whether the small tree will be able to develop into full maturity.
- Soil conditions at the source of supply and the location into which the plant will be transplanted have to be considered. A plant grown in rich lowland soil, with a soft fiber structure, will retard quickly, or even die out, in dry city atmosphere.
- City conditions, as a whole, present special technical growing problems. Rough foliage plants will hold soot which clogs the pores and the plants slowly suffocate. Smooth foliage plants are hardly ever affected by this adverse condition. The structure of some foliage makes plants more susceptible to plant diseases and insect damage. It is for this reason that evergreens cannot be maintained for any length of time under city conditions—they simply suffocate.
- Foundation plantings are often ruined when planted too close to buildings, in particular on hot south and west sides. An air space should be provided between the building and the planting.
- High buildings may cause destructive down-drafts and roof gardens face serious wind problems. In either case, plant life may be wiped out completely by wind.
- Atmospheric conditions have a vital bearing on the development and selection of plants. A very limited group of plants will tolerate sulphuric acid or carbon monoxide gas, prevalent in city and industrial areas.
- There is one more thought with which hospital administrators should be familiar. There is a serious shortage in the United States of personnel possessing a thorough, practical, working knowledge of horticulture. Frequently, janitors or engineers are appointed to take care of the grounds and plantings. This service cannot be expected of a person whose training and interests are mechanical and who is not aware of the sensitivity and requirements of plants.

All these factors help determine durability and maintenance costs of landscaping. In landscaping and "humanizing" modern hospitals, however, therapeutic and aesthetic values should receive as much consideration as cost factors. Careful planning of hospitals and surrounding landscaping will make an important contribution to medical care as well as to community planning. ■

Russian olive "half-trees" (they reach a height of 15-18 feet) serve a practical as well as a decorative function along the south and west walls at the entrance to Louis Weiss Memorial Hospital, Chicago. These walls absorb an enormous amount of heat during the summer. Temperatures as high as 120 degrees are not unusual. Only a "dry" flora such as the Russian olive can stand such conditions. This semi-tree shrub, or half-tree, also creates a pleasant proportion to the height of the walls of the building—the height of the walls is diminished and a better proportion is achieved in relation to the human figure. In addition, these plants require only a small space in which to produce a lot of greenery. The foliage is of a silver color, which produces an interesting effect against the dark background of brick and, at the same time, adds a note of elegance to the lighter colored building material. The hedges alongside the low retaining wall are buckthorn and regal privet. These plants also take a great deal of abuse and, incidentally, carry an abundance of blackberries during the winter.

◀ The landscaping design at Veterans Administration Research Hospital, Chicago, makes use of two of the most durable trees for city plantings: the honeylocust (right) and the hawthorn (left). These trees can take a "desert" climate. They are almost immune to sulphuric acid or carbon monoxide gases. They require little maintenance. Weeping willows (center) are used to supply a bold decorative note. These trees do not require an abundance of water and are fast growing. The Alpine Currant hedge (left, front) is another plant suitable for city plantings. This low-growing shrub is one of the first to develop foliage in the spring. It will grow well in half-shade and, if the area is open enough, it will also take deep shade. With a little feeding of nitrogen, or cow manure, it will create a lush planting block.

• **planning and construction issue feature**

40 DO'S AND DON'TS OF HOSPITAL INTERIOR DECORATING

by COLIN C. McLEAN

Don't enamel wall surfaces and public areas in a hospital with glossy paint. Nothing looks more unfriendly than slick, shiny walls.

Do use flat or eggshell finish paints which create an atmosphere of warmth and bring out greater depth in colors. Flat finish walls are also more flattering to the patient.

Don't neglect stairwells, where dark grey is often used. Many people pass through these areas and can be given a lift by seeing cheerful walls.

Do try bright colors in stairwells—perhaps a butter yellow ceiling with light grey walls for practicality. At each landing use a color accent in orange, rust, or bright turquoise. Since people do not stay long in stairwells, bright colors can be used here rather than where people are present all day.

THE FEELINGS OF THE PATIENT

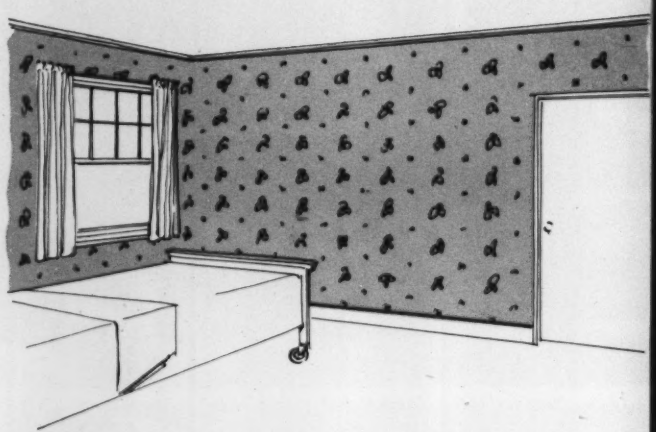
The feelings and emotions of the patient under medical circumstances require to be known and to be attended to no less than symptoms of the disease.—SIR THOMAS PERCIVAL *(1740-1804)*

Don't use dark wainscot in corridors. This is a holdover from institutions of the 1900's.

Do paint an entire corridor wall one color. If plastic wall covering is used, run it from floor to ceiling rather than using a dado.

Don't try to save money by turning out all the lights. There is no point in using bright colors if you cannot see them.

Colin C. McLean is president of Hospital Furniture, Inc., Chicago.



DON'T use loud patterns and complicated designs in patient rooms where they are likely to annoy a patient trying to rest.

Do assign people to keep lights on, especially in waiting areas. Keep all the lamps in the lobby turned on. Turn on corridor lights. Make it look as if somebody lives in the hospital. Make it cheerful. Electricity is one of the cheapest commodities you can buy.

Don't use the same lighting all along a corridor.

Do vary corridor lighting so that it does not seem like one long subway station. Waiting areas should have softer lighting. In the corridor, for example, perhaps, a picture gallery could be provided somewhere along the way with spotlights reflecting on the pictures.

Don't use only one color for both walls and ceiling in corridors. It will be monotonous and may create a long "tunnel" effect.

Do eliminate the "tunnel effect" by painting one side of a corridor in contrast to the other. Use a cool color

DO bring the outdoors into a windowless room by the use of a wallpaper mural on one wall.

on one wall and a warm one on the opposite wall. For example, warm grey and butter yellow make an excellent combination. Use an accent color in the nurses' station or at the end of corridor.

Don't use loud patterns and complicated designs in patient rooms where they are likely to annoy a patient trying to rest. For example, don't overdo the use of patterned wallpaper.

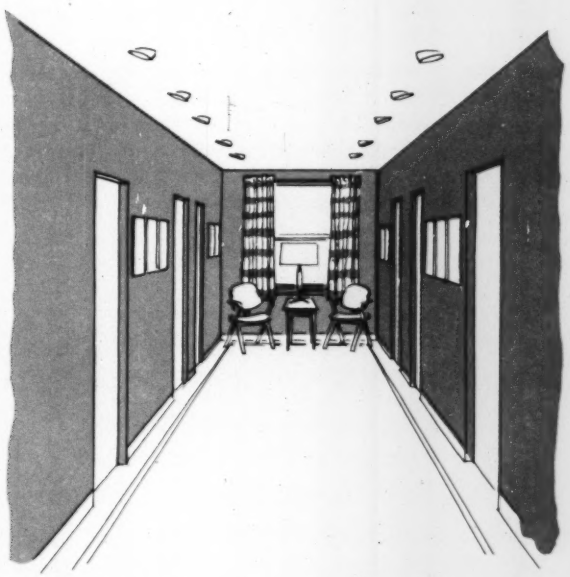
Do use designs in patient rooms that are not objectionable to a sick person looking at them all day long. Patterned wallpaper or pictures should hang where they will not bother patients. Wallpaper should be confined to one wall at the head of bed in patient rooms.

Don't hesitate to use plain draperies in patient rooms that already have one wall of wallpaper.

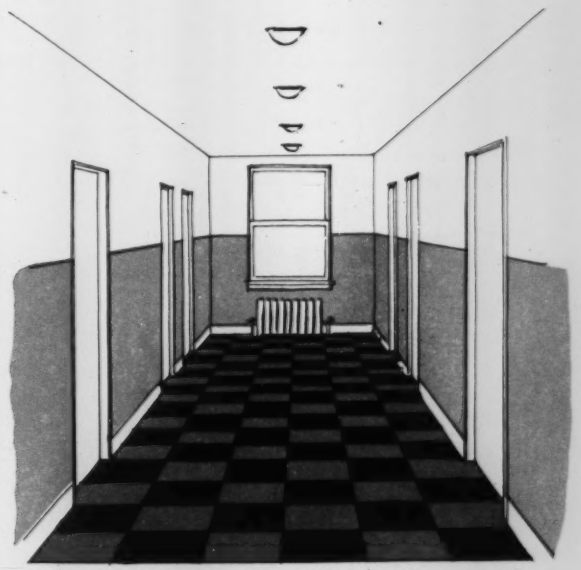
Do keep from using too many patterns in patient rooms.

Don't use "dead" white or colors that have a sickening influence in patient rooms. Avoid the use of chartreuse and wine hues.

Do confine yourself to pastel colors in patient rooms. Usually four colors are enough to give variety



DO paint an entire corridor wall one color. If plastic wall covering is used, run it from floor to ceiling.



DON'T use dark wainscot in corridors. This is a holdover from institutions of the early 1900's.

throughout the hospital. Colors can be alternated by using two warm colors in the north and east sides of the building, and two cool colors on the south and west sides.

Don't repeat the same patient room colors in public space.

Do use stronger color tones in places where people pass.

Don't use slip covers on patient chairs. They are seldom kept in place and look untidy.

Do use bright plastic upholstery, which can be easily maintained, in patient rooms. In fact, plastics should be used wherever possible. Plastic laminates, instead of glass or linoleum, should be used, for example, on desk and table tops.

Don't think that because lavatories are functional they should not be decorative. Toilet rooms are often used for meditation.

Do make tile colors in baths blend with color schemes in patient rooms.

Don't paint door and window trim contrasting colors.

Do paint door and window trim the same color as the wall to add spaciousness to the room.

Don't expect any one color to give a room cheerfulness. Color harmony—the blending of walls, draperies and chair covers—must be considered.

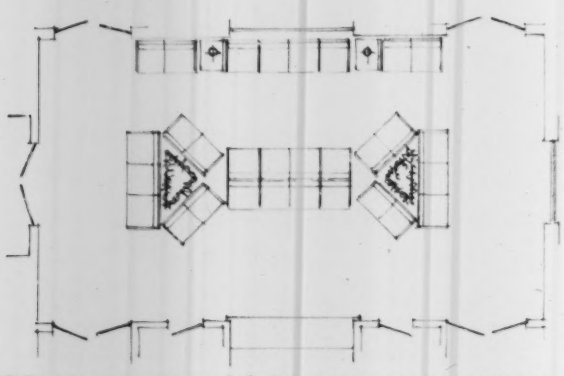
Do use accent colors in chair covers and draperies. Find places for accent colors in corridors. End walls, drinking fountain recesses and nurses' stations might well be painted an accent color to complement the corridor colors.

Don't emphasize the floor with loud colored tile or checkerboard design.

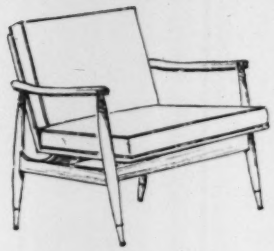
Do keep floor colors neutral. Bright floors may become tiresome and cannot be changed as easily as wall colors.

Don't use inlaid borders for corridors or rooms. This merely reduces the apparent size of the area involved.

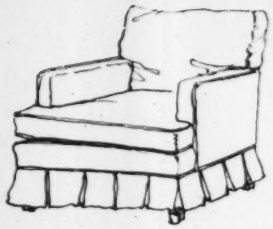
Do use bases that blend in with the floor—no need to bring attention to baseboards.



DO set up a pattern of chair arrangement that will banish the 'shoe store' look in waiting rooms.



DO use bright plastic upholstery which can be easily maintained.



DON'T use slip covers on patient chairs. They are seldom kept in place and look untidy.

Don't use loose seating for outpatient waiting areas.

Do have outpatient seating attached to the floor.

CARE WITH APPEARANCE

It may be unfortunate, but it is true, that the patient in particular, and the public in general, judge a hospital by what they see on the surface. If the entrance lobby has a tired, worn-out look, if there is grime on the kick-plate of the door, if the corridors are dimly lighted, if the decorating has been done without any professional results, it will make no difference how many pieces of expensive equipment there are in the x-ray department, or how excellent a staff is available. The public will associate care with appearance.

Remember, beauty is not expensive if it is planned in advance.—COLIN C. McLEAN, *president, Hospital Furniture, Inc., Chicago.*

Don't use benches for outpatient waiting.

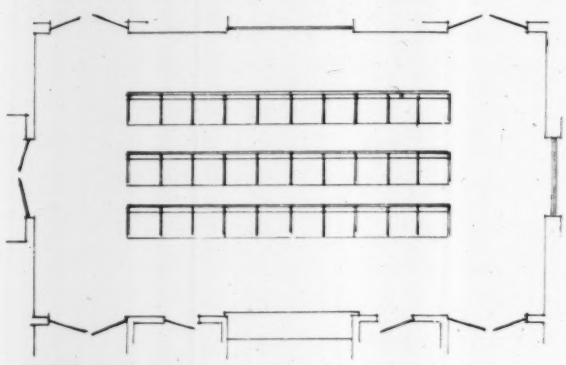
Do use chairs with arms for the ambulatory sick.

Don't arrange chairs in outpatient waiting areas in rows.

Do set up a pattern of chair arrangement, with the use of magazine racks and tables, that will banish the "shoe store" look in waiting rooms.

Don't feel that windowless areas must necessarily be drab.

Do bring the outdoors into a windowless room by the use of a wallpaper mural on one wall. This is a particular attraction for such areas as inside private dining rooms and deep therapy rooms. ■



DON'T arrange chairs in outpatient areas in rows.

• planning and construction issue feature

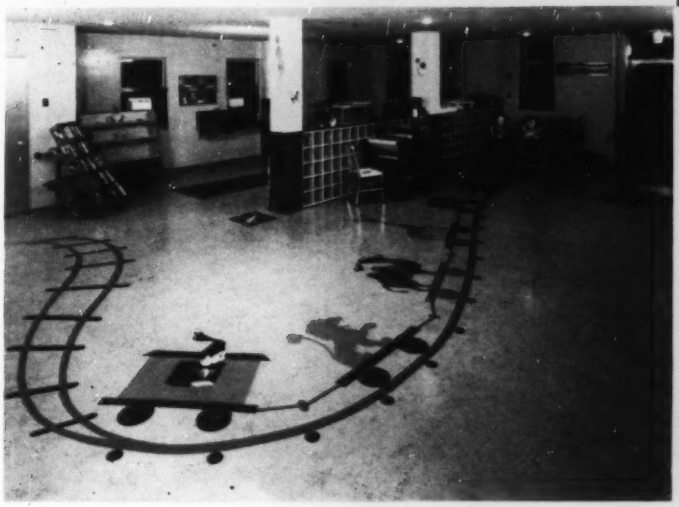
RECEPTION room in the Durkin-Banfield Clinic, Tacoma, Wash., sets the mood for open, informative consultations. Bamboo blinds move to cover the skylight when the sun is too bright. Suspended acoustical ceiling resembles travertine marble. It matches the feeling of the hand-cut stone pillar and also helps to reduce noise.
ARCHITECTS: LEA, PEARSON AND RICHARDS

(BELOW) Unusual effect is achieved in the recreation area at John J. Kane Hospital, Pittsburgh, by the use of a glazed tile wall as background.
ARCHITECTS: BUTTON & McLEAN, AND MITCHELL & RITCHEY

INTERIOR DESIGNER: MRS. E. M. SUMMERS

FUNCTIONAL BEAUTY IN HEALTH FACILITIES:

a portfolio



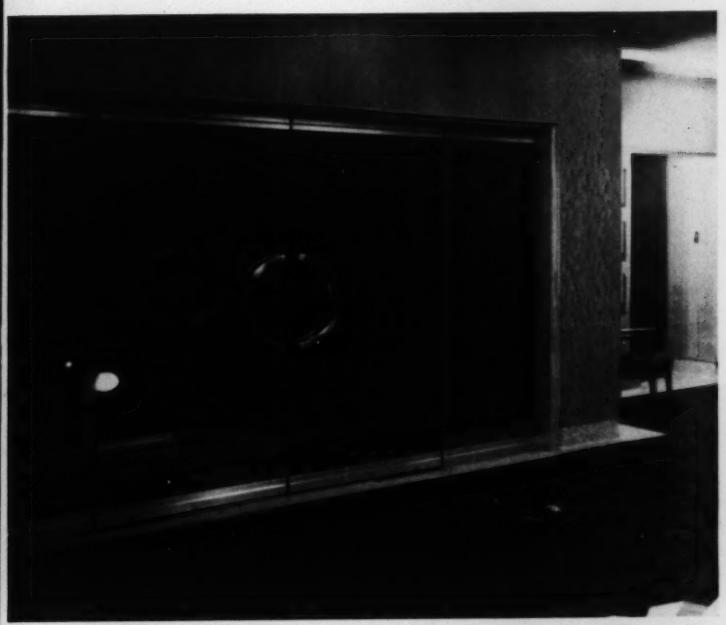
A CIRCUS atmosphere prevails in the brightly colored therapy room at Shriners Hospital for Crippled Children, San Francisco. The practical and attractive tile floor pattern includes an oversized tic-tac-toe board, a shuffleboard court, and a train complete with a menagerie.
INTERIOR DESIGNER: MRS. G. R. FOLENDORF

CHILDREN'S play area, adjacent to 15-bed children's ward at St. Joseph Hospital, Philadelpha, acknowledges in its design and furnishings that most children, even when they are sick, like to play in colorful, inviting surroundings.
INTERIOR DESIGNER: KEN WHITE

Engravings for the four-colored pictures in this portfolio were provided through the courtesy of B. F. Goodrich Co. (left and, opposite page, lower right), American-Olean Tile Co. (below), and Uvalde Rock Asphalt Co. (opposite page, upper right). All other picture credits appear on page 158.

CONTRASTING walls of ceramic tile brighten nurses' stations at the F. Hood Craddock Clinic, Sylacauga, Ala.
ARCHITECT: LAWRENCE S. WHITTEN

WARM, friendly colors are blended in the decor of the student nurses' lounge at Roosevelt Hospital, New York, to eliminate a dormitory atmosphere and help nurses and their guests feel at ease.
ARCHITECTS: KIFF, COLEAN, VOSS AND SOUDER, OFFICES OF YORK AND SAWYER



DESIGNS sandblasted into glass panels at entrance to lobby of Shriners Hospital for Crippled Children, Salt Lake City, serve a double function. In addition to being decorative, the designs identify the panels as panels and help prevent people from mistakenly trying to open them or walk through them.
ARCHITECTS: SCOTT AND BEUCHER

WHITE bench and tangerine chair of vinyl fabric accent the cypress paneling in the administrator's office at St. Joseph Hospital, Philadelphia. Sister M. Fidelis, administrator, describes the office as a "delightful place to work".
INTERIOR DESIGNER: KEN WHITE

THE *'NONINSTITUTIONAL LOOK'* IN INTERIOR WALLS

by E. TODD WHEELER

WHO CAN SAY what makes a homelike wall? Is it achieved by wallpaper or a familiar color of paint? Can we say that a few plaster cracks or hand prints of children give a homelike effect? Should the wall be of wood, plaster, stone, concrete block, plasterboard, brick, tile, glass? Does marble express the home? Do pictures and hangings create the illusion of a home?

The answer to all of these is no. And why? Because the atmosphere of home is created by more than walls alone, and because there is no uniform atmosphere even in homes themselves. What we seek to generate is a feeling similar to what we feel about our homes, that is a noninstitutional feeling, a feeling of personality. This feeling is hard to define, but it is real and worth working for.

In striving for it, we enter the field of design for effect. Here, considerations of subjective reactions go beyond the technical and into the artistic. This does not lessen the need for technical analysis of wall finishes and treatments. It does introduce factors, however, which are not susceptible of factual analysis. We encounter the psychology of personal reactions to room sizes, color and pattern; the associations or preconceptions attached to certain materials; the reactions to style and quality. Words like *warmth, smartness, soothing, elegant,* and *homelike,* appear. These words all have real meaning but the effect they describe is not attainable by a precise formula. The architect who seeks these qualities, does not himself use precise methods but designs by trial and error, relying upon his own feelings and the reactions of others to his design studies.

If I were to choose design factors most likely to achieve a homelike feeling, I would mention first variety of interior treatment, and after that, quietness and color. Uniformity, noise and drabness seem to me to be the objectionable marks of an institutional interior.

PERKINS & WILL, ARCHITECTS

FULL-LENGTH glass wall brings an outdoor-indoor effect to the waiting room at Rockford (Ill.) Hospital.

floor: asphalt tile
walls: marble and floor-to-ceiling glass with 'matchstick' draperies
ceiling: plaster

Care in the selection of wall materials and colors, states the author, can do much to dispel some of the objectionable characteristics of institutional interiors. He discusses the kind of questions that should be answered before wall finishes are selected for various hospital areas. He also appraises on a comparative basis important features of widely used wall finishing materials.

E. Todd Wheeler, F.A.I.A., is senior associate and director of hospital planning, E. Todd Wheeler and Perkins & Will, Architects, Chicago.

PERKINS & WILL, ARCHITECTS

A CHANGE in ceiling height, accompanied by a change in wall finish helps create a pleasant environment in this patient room at Rockford (Ill.) Hospital.

floor: asphalt tile
walls: plaster and wallpaper on plaster; windows with drapery
ceiling: plaster

It might be interesting to think of some of the problems to be faced in designing a wall. What is a wall? What does it do? A wall encloses, separates, conceals. It acts as a barrier to light, sound and odors. But it also reveals. It opens out into other spaces. It may conceal only partly. It provides housing for necessary equipment and piping. It may provide structural support. It offers opportunities for decoration. A wall can be friendly or forbidding; depressing or comforting.

The wall helps establish the scale of a room, which means the relationship of the size of things to the human figure. In a home, scale is achieved by the size of rooms, the height of ceilings, the size of windows and doors, and the placement of furniture. There are few long corridors or distant views in a home. There are no hollow echoes.

Sometimes in an institution, residential scale can be achieved by varying the wall finishes within a room. Variation in plan will more often do this effectively. Thus the projection into a long hospital corridor of a screen wall, or even a low cabinet or seat, will interrupt its length, shorten the view and reduce the scale of an otherwise offensively long element. Another device which might be used to break up the effect of long corridors is to finish a short section of the corridor wall in a decorative material different from the rest of the wall. This may be done where there is another element such as a drinking fountain or phone booth or a door to a stairway. Sometimes the ceiling is also lowered at that point just for the width of such treatment. Even better methods of corridor shortening are to offset the corridor at mid-point, or bend it at an angle or shorten it by using a cruciform or a double corridor plan.

WALLS ARE NOT ALWAYS WALLS

Not all walls provide solid separation. Instead of a wall there may be high or low cabinets separating adjoining spaces, as for example, a dining room from a living room. There may be plants on a trellis or in boxes or perhaps an open screen made of wood, iron, bamboo or masonry. There may be glass panels giving physical but not visible separation, drapes or movable panels which create separations at will. There may even be a sheet of water separating one space from another as a wall substitute.

There are other ways to vary the wall treatment, such as using

PERKINS & WILL, ARCHITECTS

SIMPLE materials and simple patterns keep the dining room pleasant and interesting at the International Minerals and Chemical Corp., Skokie, Ill.

floor: rubber tile
walls: rubber painted white with 'flag' inserts of enameled copper
windows: floor-to-ceiling glass with printed fiberglass draperies echoing the 'flag' design
ceiling: acoustic plaster
table tops: plastic laminate
freestanding room dividers: painted plywood

structural material like brick or stone inside and outside so the exterior wall material extends within the enclosing glass to form the interior wall. This is often done in lobbies or waiting rooms where the enclosing wall may be glass from floor to ceiling. Variations in lighting and in furnishings also achieve interest. It is quite common to see one wall of a bedroom vary in color or material from the others. Even when all walls are painted the same color, however, they will not look the same in daylight because of the different intensities of illumination each wall receives. Variety should not be sought by any method, however, at the expense of unity. A busy looking interior is almost as bad as one of monotonous uniformity. Variation in plan and in decorative features and equipment is an equally important factor in the total effect.

In the technical study of wall finishes there is much that can be done effectively to give that feeling of warmth and human scale which we associate with home. Materials should be chosen with an eye to the elements mentioned earlier; namely variety, quietness and color. This tends to limit the choice, and, in fact, may exclude certain materials. Yet such choice is essential to achieving a homelike effect.

Nor can we ignore the function of each room. For certain functions, we may be limited by other factors such as sanitary requirements, durability, availability and cost. For example, in sleeping rooms the factors of variety and color are of primary importance. This suggests selecting a wall material which is economically available in numerous colors, is low enough in cost to allow changes at relatively frequent intervals, is resistant to abrasion and decorative. If it can also be soft, i.e., sound absorbent, and washable, so much the better. For a hospital lobby, different considerations would suggest different materials. Still another conclusion would be reached for the operating rooms or laboratory—and so on through the hospital. Each material selection must consider the desired features as well as the mandatory requirements for finishes in the room of choice. (Fig. 1, page 65, summarizes features of 18 widely used wall finishes.)

How does the architect select such finishes? There is no fixed method. He considers all the qualities described and draws upon his experience to aid in selecting what he thinks will satisfy both utilitarian and aesthetic considerations. He secures special counsel of engineers and of manufacturers. He also considers the client's predilections.

The architect is always presented with the problem of making a factual comparison of materials, especially when it comes to cost The cost of wallpaper or paint may be low but to it must be added the surface required to receive it. Similarly, the cost of structural tile may be high but it provides both finish and structure. So the cost of the entire partition or wall must be calculated even to make a definitive comparison of first cost. A more difficult economic

problem is to compare first cost with final cost. First cost can be estimated rather accurately but final cost involves adding to the first cost all the costs of maintenance and replacement during the lifetime of the hospital. Here time enters in and also the cost of financing the initial investment over the period being figured.

DECEPTIVE ECONOMIES

If such an analysis is thoughtfully made there can be no question that the findings will be helpful in guiding the first selection. We must be careful, however, not to fall victim to sweet logic. It is easy to see, and sounds plausible to contend, that a durable material, though of higher first cost, will pay for itself over the years by savings in maintenance. This argument must be carefully scrutinized and questioned. Is it certain that the more durable (and more costly) material will require less maintenance? Sometimes the better the material the more often it is cleaned. Compare structural tile with painted concrete blocks in stairwells, for example. It is not impossible that the painted concrete blocks will be neither washed nor repainted for many years especially if this is a little used stair and in a relatively clean city. Yet tile may be washed routinely because it can be readily washed. If so, it is costing more to maintain than the concrete block. How then can saving of maintenance pay for the more costly material?

Or compare a plastic sheet wall finish on plaster at 60 cents per square foot with paint on the same plaster at 10 cents per square foot. It is probable that the periods of washing for the two will not be very different, or if they are, that the more durable material will in fact be washed more frequently than the painted wall, partially because it is easier to wash. Hence the normal maintenance will show no saving for the more costly material. As for replacement, the paint can be redone at least six times (perhaps 20 years) for the original price of the plastic sheet, with the added advantage of a change of color possible each time. Yet the plastic may be fully justified to resist abrasion.

Thus, the economic argument alone can be deceptive if used without regard for questions of appearance, sanitary quality or homelike character. A third consideration concerning quality and cost of material is whether the higher quality being proposed affects the pride of its users. A hospital is unquestionably judged, in part at least, by the quality of finishes in the spaces seen by the public. This may be an important reason, rather than maintenance savings, for choosing top quality materials for the walls.

FEELINGS ABOUT FINISHES

This point raises another series of questions: What are the psychological aspects of various wall finishes? Which one's do we associate with home? The answers are bound to be subjective. My own feelings about finishes may not be wholly typical but here they are:

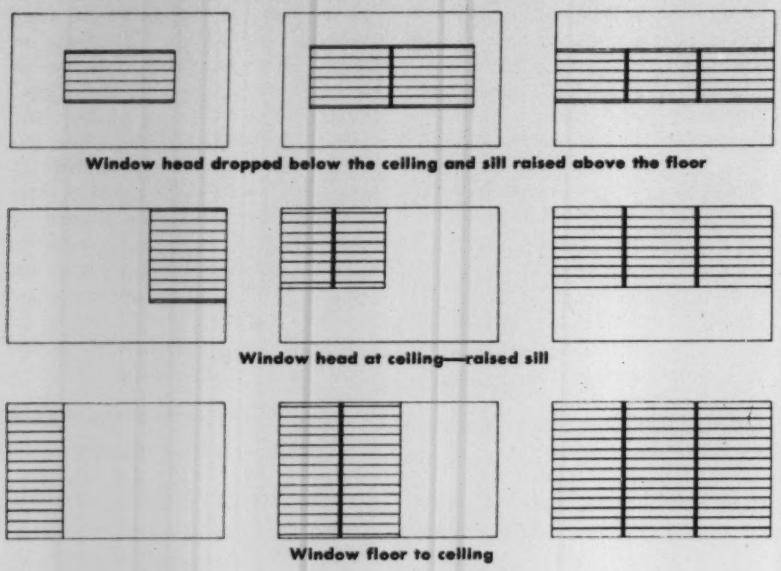
Painted plaster—Institutional in feeling but often a pleasant neutral relief from other textures if the colors are right.

Wallpapers, patterned fabrics and plastic sheets—If used with good

Fig. 1—Appraisal of qualities of wall finishes

	HOMELIKE?	DURABILITY	COST OF REPLACEMENT	SANITARY QUALITIES	ABRASION RESISTANCE	SOUND ABSORPTION	WASHABILITY	RELATIVE COST	SUBSURFACE REQUIRED	VARIETY OF PATTERN	VARIETY OF TEXTURE	VARIETY OF COLOR
PAINT	yes	short	low	good	slight	none	limited	low	anything	unlimited	limited	unlimited
WALLPAPER	yes	short	low	fair	slight	none	slight	low	smooth	unlimited	limited	unlimited
PLASTIC FABRIC	yes	medium	medium	good	good	none	frequent	medium	smooth	wide	wide	wide
LINOLEUM	yes	medium	medium	good	fair	none	frequent	high	smooth	limited	limited	wide
CANVAS	yes	medium	medium	good	fair	none	limited	medium	smooth	none	none	none
PLASTIC BOARD	maybe	medium	medium	good	good	none	frequent	high	structure	wide	none	wide
PLYWOOD	yes	medium	medium	fair	fair	slight	limited	medium	structure	wide	limited	limited
WOOD	yes	medium	high	fair	fair	slight	limited	medium	structure	wide	wide	limited
PLASTER	yes	long	medium	good	slight	none	slight	low	lath	none	limited	none
STRUCTURAL TILE	no	long	high	superior	superior	none	unlimited	medium	none	limited	limited	limited
FACING TILE	no	long	high	superior	superior	none	unlimited	high	structure	wide	wide	wide
STONE	maybe	long	high	poor	good	slight	slight	high	none	wide	wide	limited
BRICK	maybe	long	high	poor	good	slight	slight	medium	none	wide	wide	limited
CONCRETE BLOCK	maybe	medium	medium	poor	good	some	slight	low	none	wide	limited	none
CONCRETE	no	long	high	poor	superior	slight	slight	low	none	wide	wide	none
MARBLE	no	medium	high	superior	good	none	unlimited	high	structure	wide	wide	wide
ENAMELED METAL	no	long	high	superior	good	none	unlimited	high	structure	wide	limited	wide
STAINLESS STEEL	no	long	high	superior	superior	none	unlimited	high	structure	wide	limited	none

Fig. 2—Some possibilities for exterior walls in patient rooms



Window head dropped below the ceiling and sill raised above the floor

Window head at ceiling—raised sill

Window floor to ceiling

taste and restraint can give a homelike feeling. Those designed to look like something else (i.e. wood, tile, leather, cloth) give one a disappointing feeling of artificiality. Better use the real material or none at all. With proper use, however, these are the most homelike wall finishes we have.

Woods, in boards, panels, mouldings or combinations—Wood can give a homelike feeling. For a natural finish, where the grain shows, care must be used in selecting the wood for figure and color and in choosing the finish to put on it. Painted wood can also be homelike, but on fir plywood and oak the grain tends to show through. A wood surface invites the touch and is warm in feeling. This is a homelike resource.

Brick—Brick carries a feeling of solidity and quality but repels the touch because of its roughness. It also raises questions of cleanliness in hospital use.

Stone—Stone accentuates even more the qualities of brick. All such heavily textured materials must be used in limited amounts and with great restraint to avoid restlessness. With brick and stone, the use of other natural materials, such as wood and growing plants, can be pleasant and homelike.

Concrete blocks or poured concrete—When painted they can be pleasant enough and connote masonry, but I do not think these have yet become homelike. Concrete, like other masonry materials, combines structure and finish and gives a sense of stability and security. It can be textured decoratively if desired and there is no reason why it should be excluded from design resources.

Tile, marble, enameled iron and glass—All excellent materials but cold to the touch and sanitary to the eye. We have become used to them in our home bathrooms. Where frequent washing is necessary in the hospital, there can be no question of their merit, but they seldom look homelike. I suspect most of the objectionable institutional character of hospitals can be traced to these materials (with green or buff painted plaster a strong second).

Composition boards including acoustical tile—There materials do not seem homelike to me. They are not unpleasant, but they introduce a character and scale most often found in offices. They tend to force patterns (as does floor tile) which often become obtrusive. Metals, too, give a nonhomelike feeling, even copper which is the most friendly of the lot. Nothing looks more like a morgue than stainless steel and white tile.

In short, to be homelike, some mixture of color and texture in the proper places is needed with enough neutral surface to keep the whole effect from seeming overdone. Soft materials are preferred rather than hard. This calls for great restraint in design, both in the number of different materials used and in their selection and handling. It also calls for restraint in the color scheme.

TRYING THE UNTESTED

There remain the specifics of selection and how one gets factual information about wall finishes, especially the new and attractive but untried ones. Here the architect can do much of the work for you. Personal investigation can be carried on by consulting catalogues, looking at samples, referring to actual installation and inquiring into the experience of others. The literature on finishing materials is extensive. Valuable information can be found in the current periodicals and in manufacturers' publications. For the newest materials there are usually quoted tests as well as claims. I know of no agency, however, which rates materials for lasting qualities, as an engineering testing laboratory will test samples of concrete for structural strength. Much of the information in hospital periodicals deals with experience in the use of wall finishes and often that experience shows that the subsurface under the finish is as important as the finish itself.

There is another vital question about walls, namely, how are the windows to de designed? Today, it often seems as if the desire to have a horizontal band of windows on the exterior has done away with thoughtful planning of the interior. This should not be so. In patient rooms there should be careful consideration of the window treatment with special attention to the location of the bed and attendant problems of heat and glare from sunlight. There are many window combinations seen in the patients room. If we take a typical 12-foot-wide room, the window area may range from a minimum of glass to a full wall of glass (Fig. 2, above). Obviously the room layout affects this issue. If, in a single room, the bed is to be against the outside wall, full-width windows are not acceptable, but if not, they can be

considered. The issue of how much glass to provide is often hotly debated and is too extensive a problem to deal with here.

In addition to the extent of windows there are the problems of decorative drapes, closures or guards against light (roll shades, drapes, venetian blinds, louvers, projecting sun shades, colored glass or sun screens), washing facilities, ventilation, frost, heat gain in summer, drafts in winter and always cost. Then there are a multitude of details. Do you want a window sill for a shelf, and space below it for housing a heating unit and for storage of blankets? Do you want to open the windows? Are screens and storm sash necessary? Would tinted glass be desirable? To some extent the choice of finish materials for other interior walls will be influenced by the intensity of natural lighting. Thus there is much to decide about that outside wall before we can get very far on the character of the interior.

Probably the most difficult wall element to design is a wainscot, which is the lower portion of the wall. For protection, a wainscot, often is used in corridors. By introducing a long, horizontal line at its top it accentuates the least homelike quality of the corridor, namely its great length. If protection is needed, better appearance is gained by having it full height. Perhaps bumpers or railings can give adequate protection. A corridor with projecting partitions or screens with wall protection on one side and a railing on the other should be considered. This plan would give a definite path for the traffic and break up the unhomelike length while not necessarily impending bed traffic (which is the principle reason corridors are 8 feet wide).

There is no end to the variety of problems encountered in designing a wall. Technically, the wall must function as a separator of space and must resist the passage of sound, vibration, heat and air. Thereafter, its effect is largely a visual matter, though texture and radiant quality (a hot or cold material) are also factors. Thus, design starts necessarily with the technical considerations. But design must move on to blend technical considerations with psychological considerations if a homelike effect is to be obtained. When these factors are successfully merged, the result is satisfying from both a practical and an aesthetic point of view. ■

AIRBORNE BUNNY VISITS HOSPITAL NURSERY

SEVENTY-FIVE children at Our Lady of Providence nursery greeted the helicopter-borne Easter bunny when he made his landing on the grounds of Providence Hospital, Portland, Ore., last Easter Sunday afternoon. The children also participated in an egg hunt, sponsored by the local chamber of commerce.

Providence Hospital in Portland, Ore., added a new twist to the Easter celebration in its nursery last year. At 2:15 Easter Sunday afternoon several hundred persons, including 75 youngsters from Our Lady of Providence Nursery, gathered on the hospital's grounds to welcome the arrival of a life-sized Easter bunny via helicopter.

The helicopter and its long-eared passenger touched off the most publicized Easter egg hunt in the State of Oregon, reports Sister Ruth Marie, R.N., hospital administrator. Several days before and after Easter, Portland newspapers and television and radio stations carried feature stories about the hunt.

Even more important than the publicity, recalls Sister Ruth Marie, was the very obvious enjoyment that the children received from seeing the airborne bunny. Their enjoyment was extended to the egg hunt, in which they managed to gather more than 400 Easter eggs within 15 minutes.

The hunt was sponsored by the Parkrose Junior Chamber of Commerce. The helicopter was donated by a Portland helicopter corporation. ■

Greek medicine

Pre-Columbian trephining

Medieval Arabic oral surgery

Renaissance anatomists

19th century scraping of vaccine

Universal medicine

Sculpture for the Gates Memorial Pavilion, University of Pennsylvania Hospital, Philadelphia. MILTON HORN, sculptor. SCHMIDT, GARDEN & ERIKSON, architects.

A SCULPTOR

THE CLOSE ASSOCIATION of sculpture and the healing arts is very ancient. In fact, from earliest recorded times, the two were inseparable, as archaeological evidence shows. Yet, the cause for its minor role, or for its total neglect in many hospital designs today is largely due to the misunderstanding of the meaning of sculpture in the sense that it will be used here. Were it merely an art, or a craft, whose sole purpose is decoration, it could, like other luxuries, be added or omitted at will. Or, were it merely a means of self-expression of the sculptor, its validity in the hospital could be seriously questioned. But sculpture, true sculpture, is much more. Let me try to explain it by analogy.

The word *writing* denotes the act of putting communicative signs on paper. But it does not define the level of that communication, which could be anything from a child writing, "My cat is black," to a verse from the prophet Isaiah. So it is with sculpture. The word denotes the act, but does not define the level of performance.

I am not going to use the words *art* or *aesthetics*. Instead, I will use the phrase *mythopeic* sculpture. On the surface, such a phrase seems at best highbrow and at worst frightening. But it serves a helpful function because, unlike *art* or *aesthetics*, it denotes the *nature* of sculpture and helps to explain its purpose for being.

Perhaps the following will make this point clearer.

Myths are creations in sculptured forms and also in words that give man a sense of spiritual

Milton Horn is a sculptor. His studio is in Chicago.

LOOKS AT HOSPITAL DESIGN

by MILTON HORN

Sculpture, states the author, can be much more than a decorative element in hospital design. He discusses and defines the mythopeic intent of sculpture, traces its history, and describes how it can be used effectively in our present era of specialization.

orientation. In this way they have great psychological impact on him. An example of this kind of spiritual orientation is man's concepts of gods whose acts symbolize to him ordering, unifying and protecting forces. In spite of the fact that these gods are man's creations he could not psychologically survive without them. To cite great and familiar examples we have but to look at Homer, the Old and the New Testaments, the great sculptures of Egypt, China, India, Greece, Europe and pre-Colombian Americas. The mythopeic sense is the common heritage of all men. It should not be confused with legends or tall tales.

From time immemorial, man, motivated by the need to comprehend the living forces around him and to grapple with the great mysteries that awed him—birth, metamorphosis, pain, death, the changing seasons—found the need for mythopeic sculpture. This sometimes took the form of composite creatures combining man, beast and bird into one image so that the controlling spirits (gods) could abide in them. These composites denoted that the gods manifested themselves through all aspects of life. In a time of joy or pain or crisis man came to the mythopeic image to pray, to sacrifice, or to consult. For him, mythopeic sculpture was a symbolic image that embodied the source of his faith.

Today such sculpture still is the symbolic image of wholeness.

The healing arts have long recognized that the patient should be treated as a whole man. It follows that hospitals should provide a congenial setting for this kind of treatment. History supports this argument.

The ancient Greeks, for example, organized their hospitals upon the principle that man's biologic-mythopeic-sociologic nature is indivisible. In his *History of Medicine*, Arturo Castiglioni wrote of Hellenistic Greece:

> **"The temples of Aesculapius were usually built in places where the position and natural beauties of the surroundings made them particularly suitable as places to treat the sick. They were very often built near the sea, with its refreshing breezes; they were architectural masterpieces and were adorned with works of art by the finest masters."**

Further on, Castiglioni wrote:

> **"Towards the end of the fifteenth century, hospitals were already well organized, and especially in the larger Italian cities magnificent edifices with notable sculptures were erected to receive the sick. The Hospital of the Ceppo at Pistoja is ornamented with the marvellous bas-reliefs of Giovanni della Robbia (1469-1529), the chef-d'oeuvre of this artist and an important iconographic contribution to the history of medicine."**

Since the post-Renaissance (from the 17th century on) there has been a tendency to ignore the mythopeic nature of man. Sculpture and painting were torn from the mother art, architecture, and from the social body to become luxurious bric-a-brac used as cultural ostentation. With rare exceptions, the mythopeic side of architecture was forfeited. Borrowed architectural forms were used bereft of their original indigenous content. They became cliches or cloaks to cover the community's cultural and spiritual insecurity.

When architecture finally wrenched itself from this kind of design, the organic poetry of form was almost atrophied. Breaking out of one prison the architect found himself running into blockades: the "scientifically" and "economically" oriented client had become numb to mythopeic images.

Weaker architects, dulled by years of dependency on misunderstood borrowed forms, were unable to handle modern technology as a medium towards mythopeic architecture. Their architecture became enslaved to the impersonality of the machine, and the lusty youngster, science, emerging from the darkness of its primitive shell, assumed a self-centered discipline in its specific fields of activity, and in matters of the spirit, it was anarchic.

There are other problems we still face. The mythopeic spirit is the keystone of the whole man who now is being virtually ignored. He has been replaced by the specialist. In medicine, of course, this is particularly true. All scientific and technological actions are, in a way, chains. Each link feels only its immediate neighboring link. Even in ordinary labor, specialization makes a man's activity but a small fragment of a process. This emphasis on specialization, which ignores the mytho-

peic nature of man, is reflected in the design of most contemporary buildings, including hospitals; they are mythopeically faceless.

The problem we now face is the re-awakening of the sense of wholeness in man. This is where mythopeic sculpture can make its vital contribution. There are many places in hospitals and medical institutions where mythopeic sculpture can be effective. Exteriors, for example, commons rooms, open courts and gardens are places where great mythopeic sculpture can help dispel the feeling that a patient is but a machine in for repair.

There have been some recent examples of hospitals making use of sculpture and painting in their design. In most cases, however, it was thought of as a merely decorative element, or as a means of identifying the institution by a statue of Hippocrates, or, perhaps, a nurse. It is not the subject matter that is at fault. It is the unimaginative, superficial, feelingless treatment of these subjects that is often accompanied by overtones of mass production.

PRACTICAL EXAMPLE

One of the most appropriate places for incorporating the mythopeic image is in a medical center, where the learning process and the healing of man commingle. This approach was made at the new medical center of West Virginia University, Morgantown, where the school of medicine and the hospital are architecturally interlocked.

From its inception, the architects (C. E. Silling of C. E. Silling and Associates, Charleston, W. Va., and Vale Faro and Rudolph J. Nedved of Schmidt, Garden and Erikson, Chicago) considered sculpture as a limb of the whole. I was called in early in the planning as sculptor. I was shown the plans, the location of the sculpture and was given four monumental, marble pylons to work on. These pylons are an integral part of the architectural composition. The motifs that were to be used and the treatment of the forms were left to me.

While I had done sculpture for hospitals before, I did further extensive reading to expand my sources for subject-motifs. No matter what project a sculptor undertakes, he must have more than an average knowledge, plus sympathy, for the field from which he draws his subject matter.

Since the pylons were to be at the entrance of the medical school [see cover], I felt that along with their mythopeic functions they should also carry an historic orientation for the medical student. The medical events selected for motifs had not only to be historically momentous, but also suitable for sculptural treatment. More subject-motifs were selected than could possibly be used. This gave me a wide range of selection in creating my compositions. In some of the reliefs historical motifs from different fields of medicine that occurred decades and continents apart are woven into an organic whole.

With all the basic information at hand I built working scale models of the pylons, scaled two inches to the foot. With blue prints of the building plan in relation to its topographical setting and elevations before me, I began to compose the reliefs on the pylons, trying out many schemes and sculptural treatments.

While the experimenting progressed, I had in mind the great number of people of diverse backgrounds who have no knowledge of the history of medicine, but to whom these sculptured pylons should evoke a mythopeic affinity. I have found that, in most cases, the observer's first natural reaction to a work of sculpture is the mythopeic impact: he simply reacts to a drawing power, if it is there.

When the preliminary sketches were done, a meeting was held between architects, sculptor and a member of the building committee. All agreed that the approach to scale, treatment and subject matter was appropriate. It was now ready to be presented to the building committee and faculty of the medical school. I therefore used photographs of the preliminary studies in my presentation to this group and described the sculpture's function in relation to the medical center as a whole. I also showed slides of mythopeic images from many parts of the world and periods of time to illustrate my concept of mythopeic sculpture and to show how sculpture differs from anatomical imitation of nature. The sculptor's function is not that of the anatomist, for stone, wood and bronze are of different material substance and structure than man and beast; forms evoked in these materials live in a mythopeic context, which is different than the biologic context.

Proportions within the mythopeic sculpture also differ from nature's proportions. For example, while in nature an elephant is larger than a man, in a mythopeic sculpture it might be the reverse, depending upon the role of the form in the context of the whole. The structure of every mythopeic sculpture, if it is truly a mythimage, has a logic of its own governed by the need specific to its function, whether it be a beautful Indian bronze of the many-armed Siva, or a fine example of an Egyptian sphinx in basalt, or the seemingly realistic Moses by Michaelangelo, or Donatello's dancing putti. Mythimages like these appear so organically right to the eye, mind, and heart that it does not occur to the observer to question their anatomical correctness.

During the process of developing the full size sculpture the work continually underwent changes in the arrangement of the forms. Then the sculptured marbles were moved from Chicago to Morgantown, where I completed them, making such emphasis in the forms to heighten the visual impact as unforeseen conditions required *in situ*.

The sculptured pylons are not the only integral sculpture in this medical center. The hospital now under construction will have in it an interfaith chapel*. The architects and I felt that this should not be an austere or impersonal room, which seems to be a characteristic of many chapels that try to accommodate impartially the Protestant, Catholic and Jewish faiths. Nor, we felt, should it be a room whose focal point was innocuous abstract forms lacking in mythopeic significance.

Because it was thought of early enough in the design stage, the composition of the sculpture and

*Rebecca Silling Chapel

PRELIMINARY studies of the Rebecca Silling Chapel, which will be located in the hospital at West Virginia University medical center, Morgantown, show the chapel as it will look during Jewish services (left), and during Protestant or Catholic services.

SCHMIDT, GARDEN AND ERICKSON, AND C. E. SILLING AND ASSOCIATES, ARCHITECTS

the chapel developed together.

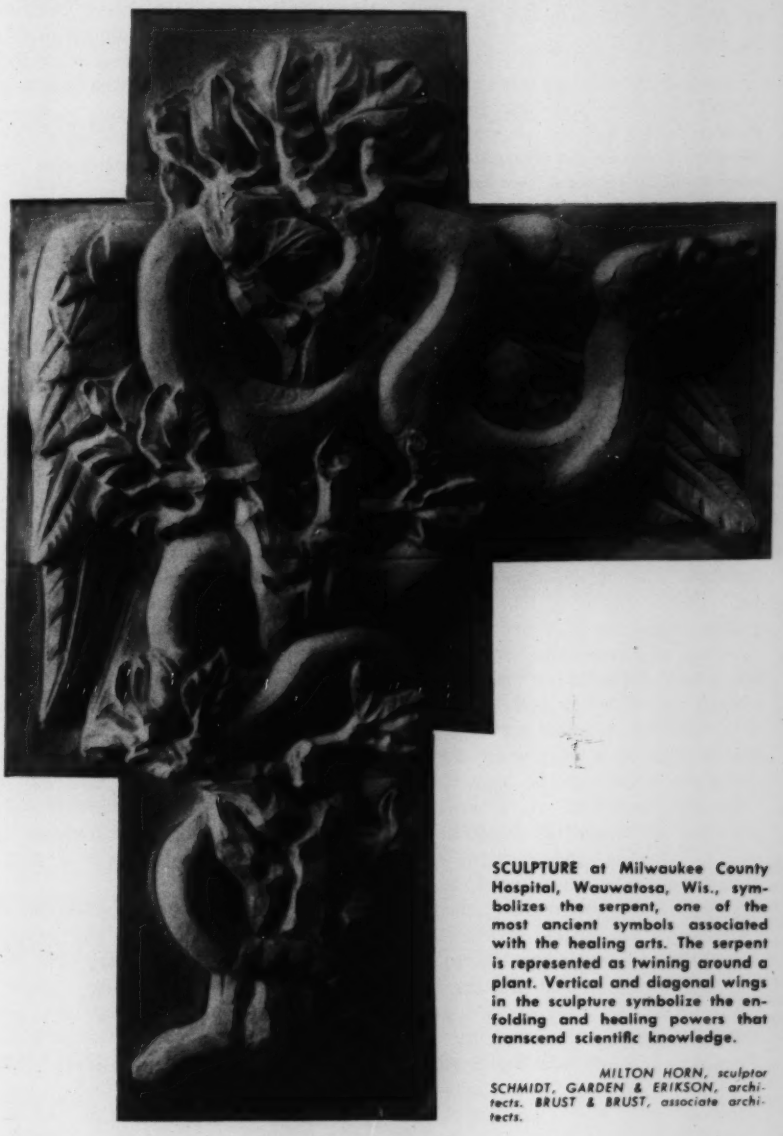
The sculpture serves the dual function of a Holy Ark and a reredos. The subject-motif is from Isaiah 6:3:

> **"And one cried unto another, and said, Holy, holy, holy, is the Lord of hosts: the whole earth is full of his glory."**

This verse is an integral part of the ancient Jewish liturgy, of the Catholic Mass and the Protestant Communion. The ark opening, which is part of the total design, is large enough for the Torah-scroll (Pentateuch). The Torah-scroll, however, is there only during the Jewish services. The altar, which is movable, is drawn forth from the free-standing arkreredos for the use in Protestant and Catholic ritual. At these times, the opening will be closed by a translucent gold curtain. The interior of the ark is to be lit through a gold glass top, the light coming from the same source that will light the whole sculpture.

Foremost in our minds was that the chapel must be a place where the mythopeic spirit of man can find itself oriented, a sanctuary radiating a sense of "the beauty of holiness." When people of different faiths find the need for meditation and are in the chapel at the same time and the symbols of their specific faiths are not in their presence, the sense must prevail that they are not in an alien place.

It is only when each can be himself and at the same time feel himself an integral part of the many that man is truly man. The glory of man is that he needs and creates mythopeic images that are his tangible symbols of the unity that underlies diversity. ■



SCULPTURE at Milwaukee County Hospital, Wauwatosa, Wis., symbolizes the serpent, one of the most ancient symbols associated with the healing arts. The serpent is represented as twining around a plant. Vertical and diagonal wings in the sculpture symbolize the enfolding and healing powers that transcend scientific knowledge.

MILTON HORN, sculptor
SCHMIDT, GARDEN & ERIKSON, architects. BRUST & BRUST, associate architects.

ASSOCIATION SECTION

The following actions were taken by the Board of Trustees of the American Hospital Association at its meetings on Feb. 3. Further actions of the Board will be reported in subsequent issues of this Journal.

The following two statements, relating to hospital pharmacists, were approved by the executive committee of the American Society of Hospital Pharmacists on Feb. 24, 1959.

PART-TIME PHARMACISTS

VOTED: To approve the Suggested Principles of Relationship Between Smaller Hospitals and Part-time Pharmacists Who Provide Pharmaceutical Services.

SUGGESTED PRINCIPLES OF RELATIONSHIP BETWEEN SMALLER HOSPITALS AND PART-TIME PHARMACISTS WHO PROVIDE PHARMACEUTICAL SERVICES

Preamble

All hospitals should be cognizant of the contribution made by a sound and organized pharmaceutical service for improved patient care and treatment. The introduction annually of numerous potent drugs requires that all hospitals have the full or part-time services of a registered pharmacist. In small hospitals which cannot obtain or afford a full-time hospital pharmacist, the services of a pharmacist on a part-time or consultative basis may be obtained.

If the services of a hospital pharmacist of another hospital are not obtainable, the services of a local registered pharmacist should be utilized whenever possible. When pharmaceutical service from a local pharmacy is considered, the part-time pharmacist and the hospital might consider certain guiding principles of affiliation. *The Principles of Relationship Between Smaller Hospitals and Part-time Pharmacists* are suggested to achieve the objective of better patient care.

Basic Principle

1. *The pharmaceutical service of the hospital shall be organized and maintained primarily for the benefit of hospital patients.*

In any hospital, the individual elements which are maintained and coordinated are all subordinate to the main objective of providing care to the sick and injured. Any function either newly added or strengthened, as in this instance drug or pharmaceutical services (from any source whatever or by any arrangement), must be in agreement with this basic principle.

Organization

1. *The hospital pharmaceutical service should be under the direction of a professionally competent, legally qualified pharmacist.*

The hospital must exercise due care in its selection of personnel. The hospital safeguards the patient and its public trust by fixing the responsibility for its varied functions by appointing adequately qualified individuals.

2. *A part-time pharmacist, as a professional member of the hospital staff and as the head of a hospital function or department, must assume the responsibilities involved.*

Recognition as a member of the hospital organization will be in direct proportion to the responsibility which the individual is capable of accepting on a part-time basis.

3. *The part-time pharmacist shall be responsible to the proper administrative authority of the hospital for developing, supervising and coordinating the activities of the pharmaceutical services to hospital patients and departments.*

With hospital affiliation, an attendant responsibility is placed on the part-time pharmacist to preserve the unity and coordination of the hospital's component activities as directed by the administrator in policies laid down in behalf of the public which the hospital governing board represents. Thus the part-time pharmacist subscribing to a hospital connection in terms of relationships, is primarily responsible to the hospital administrator for those services provided to hospital patients and departments.

Rules, regulations and procedures regarding drug services to hospital patients and departments should not be counter to or in opposition to the hospital's policies for patients as interpreted and approved by the hospital administrator in behalf of the medical staff, and of the hospital governing board and the public it represents.

4. *The organization of hospital pharmaceutical services, the relationship to the hospital and its elements, and the specific services to be provided should be outlined and reviewed periodically by the hospital administrator and the part-time pharmacist who provides pharmaceutical services to hospital patients and departments.*

To keep abreast of changing developments or staff demands for high standards of service and to obviate misunderstandings, relationships should be outlined initially and reviewed periodically. This appears to be particularly necessary in those situations where certain elements of services are provided on the hospital premises,

(Continued on page 140)

OFFICIAL MEETINGS

March 18-19	**Subcommittee on Hospital Architects' Qualifications**	**Chicago**
March 20-21	**Joint Council**	**Chicago**

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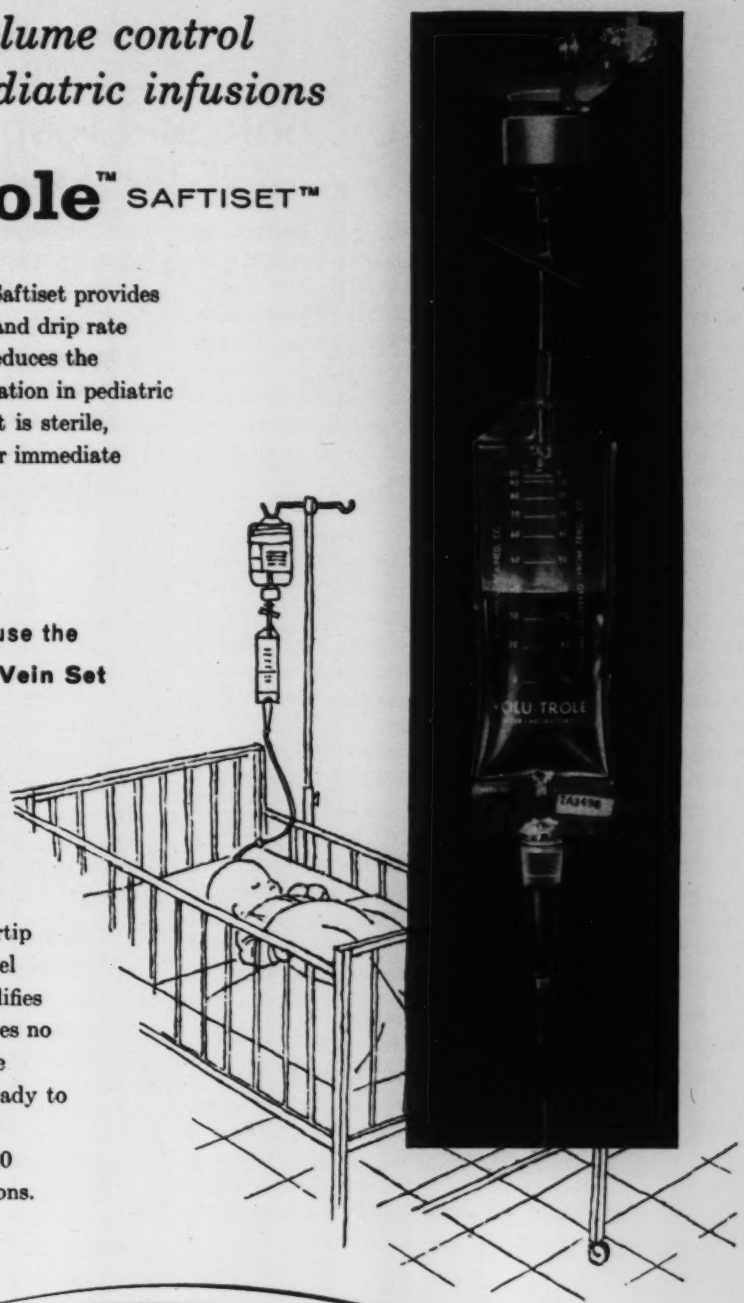

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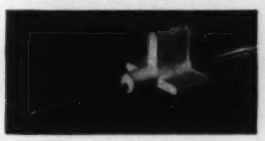

Saftigrip provides easy fingertip control, holds the needle bevel in correct position, and simplifies insertion. Infusion Set requires no head restraints. Baby is more comfortable. Set is sterile, ready to use. Available with 23 gauge needle for fluid infusions or 20 gauge needle for blood infusions.

also available:
K-N-L®
(Darrow's Solution)
for potassium replacement in infantile diarrhea

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CUTTER LABORATORIES Berkeley, California

[Advertisement]

Take a Close Look at Hospital Injectables

Reading time: 2½ minutes **Benefits: 12**

There is little doubt that disposable equipment has assumed great importance in the modern hospital. Certainly, no hospital administrator would dispute the fact that disposable items such as knife blades, blood lancets, urine collection bags, catheters, and enemas all help increase efficiency and, often, cut costs.

On the other hand, much can be said for equipment of a more permanent nature. Personnel have usually had experience with it. There's no need for constant re-ordering; the cupboard is rarely bare.

You can have both

The advantages of disposable and permanent equipment do not necessarily have to be separate and distinct. In the TUBEX® closed-system of injectables, for example, the best features and advantages of both are combined. The system comprises a durable, finely made syringe and a disposable cartridge (glass) and needle unit containing a pre-measured dose of medication.

Injection with TUBEX *simply requires that the proper pre-filled cartridge-needle unit be selected, inserted in the syringe, and aspirated. After the injection has been given, the cartridge-needle unit is discarded; the syringe is ready to use again . . . and again . . . and again . . .*

The benefits that the TUBEX system brings to hospital personnel, and the contributions that it makes to hospital efficiency and the welfare of patients, are impressive. Consider, if you will, the following examples.

1. Accurately measured dose assured
2. Danger of giving wrong drug reduced

Each sterile cartridge-needle unit contains an accurate, clearly labeled dose. Therefore, the nurse no longer must measure out doses as before—perhaps from an often-used, possibly contaminated multiple-dose vial. She runs little risk of administering an inaccurate dose or, worse yet, the wrong drug entirely. Obviously, the less chance for error the fewer the number of malpractice suits.

3. Efficiency of Central Supply increased
4. Breakage losses reduced

TUBEX cartridge-needle units are pre-sterilized; the needles pre-sharpened. This means that Central Supply can turn its attention to duties other than the time-consuming sterilization of syringes and the sharpening and sterilization of needles. It also means that breakage, which invariably accompanies these operations, and which raises the hospital's costs, is drastically reduced.

5. A source of hepatitis eliminated
6. Contact sensitization minimized

TUBEX cartridge-needle units serve for a single injection only. There can be no contaminated needles to transmit serum hepatitis or other diseases. Also, because there is virtually no chance for spillage, the nurse rarely comes into contact with drugs that might produce dermatitides or be absorbed to cause even more serious effects.

7. Inventory control simplified
8. Narcotic security tightened

The TUBEX system requires only two parts, half as many as the "conventional" system.

TUBEX System: cartridge-needle unit, syringe
Conventional System: plunger, barrel, needle, medication

There are fewer records to keep. Inventory control, therefore, is more accurate and efficient. As inventory control becomes more accurate, narcotic security automatically tightens.

9. Patients react more pleasantly to injections
10. Most commonly used drugs available

The most obvious direct benefit that the TUBEX system provides for the patient is a relatively painless injection, the result of a fresh, pre-sharpened, single-use needle. Since most common drugs—and many uncommon ones as well—are available in TUBEX form, the majority of hospital patients can benefit from the TUBEX system.

11. Accounting made more efficient
12. Billing made more accurate

Since each cartridge-needle unit contains a single, pre-measured dose, the amount of medication, including narcotics, that is given a patient is readily ascertainable. Hence, accounting is facilitated and the proper charges to the patient can be made accurately and easily.

In summary

As you can see, adoption of the TUBEX system can have far-reaching effects. Efficiency and morale of the staff are improved. Labor costs—currently about 70 cents of every dollar spent by the hospital—are markedly reduced. Accounting, billing, and inventory control are made more accurate. The risk of malpractice suits is mitigated. The well-being of patients is enhanced.

The TUBEX system can presently supply more than 75 per cent of injectables commonly administered in hospitals. And medications not yet available in TUBEX form can be administered by means of empty, sterile cartridge-needle units. Thus, the TUBEX system is capable of meeting every need for injectables.

The TUBEX system is already in wide use. To learn more about the many benefits that the TUBEX system can bring to *your* hospital, please see your Wyeth Territory Manager or write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.

CAUTION SIGNS
for radium handling

by ROBERT W. SATTERFIELD

An industrial hygienist reviews the dangers inherent in radium handling, and sets forth a set of recommended safe practices designed to reduce the potential hazards arising out of the use of radium in hospitals. Emergency procedures to be applied if a radium container bursts or is lost are also outlined.

RADIATION EMITTED by radium cannot be detected by any of the five senses. A person can be exposed to radiation of sufficient intensity to produce permanent damage or even death, and yet be completely unaware of the exposure. Obviously, adequate precautions must be taken to prevent accidental high exposure.

Radium undergoes a series of radioactive decay processes, during which strong radiation is produced in the form of alpha and beta particles and gamma radiation. Such radiation has the property of damaging and killing living cells if exposure is permitted in sufficient intensity over any given time interval.

Therapeutically, radium can be used at a distance (telecurietherapy), applied directly to the skin surface, implanted in the body or inserted into body cavities. The increased use of modern x-ray equipment and radioactive isotopes has practically eliminated telecurietherapy and greatly reduced the practice of applying radium directly to the skin.

Radium is usually employed in the form of a salt, such as the chloride or sulfate. Milligram quantities, the amount depending upon the radiation dosages desired, are encased in platinum, palladium or stainless steel containers and used in this form. The encasement is used not only to prevent escape of the radium and radon gas, but also to filter out alpha and beta radiation, which causes severe local burning during therapeutic application.

During application, these radium containers are placed in various types of applicators or threaded together to obtain the desired quantity and distribution of radiation.

Robert W. Satterfield is industrial hygienist for Lumbermens Mutual Casualty Co. and American Motorists Insurance Co. (divisions of the Kemper Insurance Group).

MAXIMUM EXPOSURES

As with poisons, radiation can be tolerated within certain dosage limits without appreciable effect. The safe weekly dose of exposed workers has been established at 300 milliroentgens (mr.). However, the total accumulated dose should not exceed five times the number of years of age beyond 18, provided no annual increment exceeds 15 roentgens.

An accidental or emergency dose of 25 roentgens (r.) to the whole body, occurring once in the lifetime of a person, is assumed to have no effect on the radiation tolerance of that individual.

Fortunately, radiation can be measured by such instruments as Geiger counters and ionization chambers, or by measuring the amount of change produced on special photographic film.

Basic approaches to the prevention of excessive radiation exposures are: (1) to provide adequate shielding between the radiation source and the exposed worker or person, (2) to limit the time of exposure and (3) to maintain adequate distance between personnel and radiation sources.

Every hospital should draft a safe procedure for radium handling commensurate with the needs of the hospital. By strictly adhering to such a safe handling procedure, the possibility of excessive radiation exposure to hospital personnel can be eliminated.

RECOMMENDED SAFE PRACTICES

Following are recommended safe practices designed to reduce the potential hazards arising out of the use of radium in hospitals:

1. A radium handling program should be developed, specifically outlining each step to be followed in receiving, storage, transportation within the hospital, use and returning to the original source.

2. Radium should be stored in lead containers having sufficient thickness to reduce radiation to safe levels in surrounding areas. Chart 1 indicates the thickness of lead necessary to reduce radiation levels to 50 mr. per hour at a distance of one foot, for various quantities of radium. This level is chosen arbitrarily to keep the dosage received within allowable personal limits and also to keep the amount of necessary lead shielding practical enough to let personnel work with required radium quantities. Chart 2 indicates radiation levels measured in milliroentgens at 1, 2, 3, 4 and 5 feet from the source. The radium stor-

age container should be kept in a safe, vault or other location at least three feet from the normal working position.

3. Radium should be transported within the hospital in a lead container equipped with suitable handle so that the container is at least one foot from the person carrying it. The thickness of this container should be such that the radiation level does not exceed 50 mr. per hour at one foot.

4. Preparation and manipulation of radium should be performed on a special table having a one-inch lead plate covered with linoleum or other suitable material. Radium should be handled by tongs or other remote handling equipment from behind a screen of sufficient dimensions to shield the entire body. The top of the shield should be equipped with a leaded glass viewing window. The tongs, forceps or other instruments used for handling radium should have handles at least 10 inches long.

5. Surgeons and nurses in attendance during the administration of radium should wear leaded aprons which cover the maximum possible area of the body. However, since leaded aprons offer limited protection from radiation, it is desirable for persons in attendance to maintain the maximum distance possible from the radium during administration and remain on the scene as briefly as possible.

6. After radium has been implanted, no visitors should be allowed, and other patients should be kept at a minimum distance of 10 feet. If it is necessary for any one nurse to administer nursing care for a period longer than 10 minutes during any day, a leaded apron should be worn. Even with the apron, however, the length of exposure should be carefully controlled.

7. Hospital personnel using radium should have complete physical examinations before employment and annually thereafter. It is considered advisable that the examination include a complete blood count. Abnormal blood counts which result from high exposures to radiation occur after permanent injury. The purpose of the blood counting procedure, therefore, should be to locate those persons with abnormal blood pictures caused by other than radiation exposure and to eliminate them from radium handling.

8. Special photographic film badges should be worn by all personnel handling radium. These film badges should be submitted for processing at least every two weeks. If a film badge indicates an exposure in excess of 300 mr. during any week, this person should be removed from further radiation exposure until sufficient time has elapsed to bring the average weekly exposure below 300 mr. Permanent records should be kept of results of exposures as recorded from film badge readings. One copy of these reports should be kept in the hospital personnel folder.

9. Permanent records (logs) should be kept regarding all use of radium. Suggested information to be recorded includes date of use, time, name of person or persons removing radium from storage; amount of radium used; name of nurse and surgeon using radium; patient's name, date period of treatment, and name of person returning radium to storage.

10. In the event radium is lost or spilled through capsule breakage, local and state health officials and the insurance carrier should be notified immediately. It is essential that any spilled radium be located and the contamination of work areas or equipment be held to a minimum.

11. Special situations not falling within the above should be given individual consideration and the appropriate safe practices devel-

CHART 1

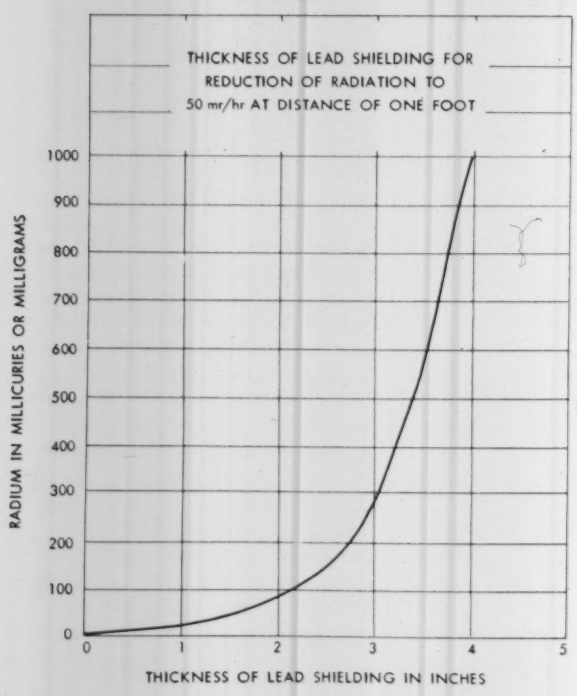
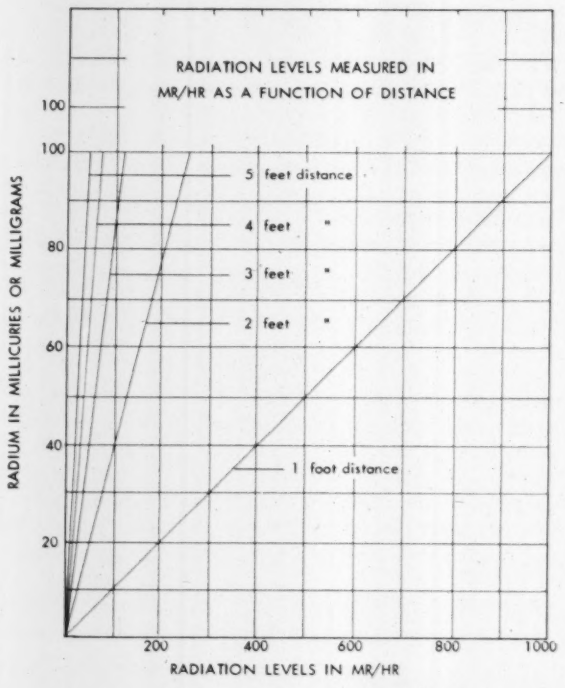
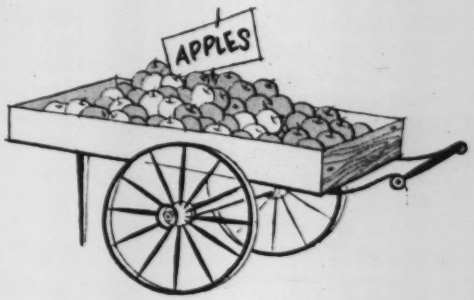


CHART 2



The Pushcart in the Hospital Pharmacy

A candid look at the need for inventory control in small hospital pharmacy operation



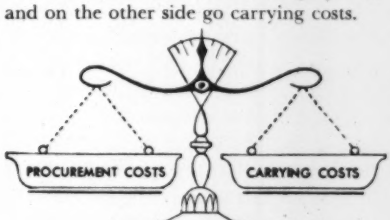
by Alfred A. Mannino
EXECUTIVE DIRECTOR, HOSPITAL DEPT.
McKESSON & ROBBINS, INC.

The key to successful hospital pharmacy operation is inventory control. There's a very simple way to demonstrate how costly improper inventory control can be. The pharmacist has only to look at Tony, the pushcart peddler, who faces this problem every day. If Tony starts his rounds with too many apples, he will expend extra energy all day long pushing a burden left unsold at the end of the day. On the other hand, if he starts with too few apples, he will run out and have to expend extra energy going back for more.

The same is true of the hospital pharmacy, except that where the pushcart peddler pays for improper inventory control in energy, the pharmacy pays in money. Indeed, the entire hospital operation may be endangered by lack of inventory control in the pharmacy, for almost a third of every hospital supply dollar goes for pharmacy purchases.

Many people are frightened by inventory control, and certainly it presents a far greater problem for the hospital pharmacist than it does for the pushcart peddler. But the fact is that the principles of inventory control remain the same, whether the inventory is the some 7,000 items with which the average hospital pharmacy deals or the single item of apples faced by our pushcart peddler.

Basically, inventory control is balance—the balance of two sets of costs which together make the total cost of operation. On one side of the scale go procurement costs, and on the other side go carrying costs.



These two costs constantly affect each other. A decrease in procurement costs will cause an increase in carrying costs, and vice versa. When the scale tips one way or the other, inventory control is not functioning properly. The scale will balance, however, when you reach the level at which the combined costs of procuring and carrying inventory are at a minimum. Then, inventory control is functioning to make your pharmacy operation as profitable as possible.

What are the factors involved in these two sets of costs? Procurement costs consist of the time and money spent in replenishment studies, purchase actions, receiving stock, inspecting stock, and of course, paying for stock. Carrying costs consist of elements such as interest, obsolescence, loss through theft or damage, deterioration and storage.

The size of the hospital pharmacy inventory is obviously of great importance. Large inventory, with its corresponding increase in carrying costs, has long represented a major threat to proper inventory control. Today, however, smaller inventory is no longer a problem. McKesson & Robbins Hospital Service Department is proud of the part it has played in helping to make smaller inventories possible through its fast delivery service. With 84 warehousing units located strategically throughout the country, a local source of supply is available any hour of day or night for emergency deliveries as well as routine service.

Just as McKesson & Robbins saw the need for supply service which would make smaller inventory possible, it also has long been aware of the many other problems you face in achieving proper inventory control in your hospital pharmacy. Its experience in specializing in the business problems of hospital pharmacies is one reason why 60% of the nation's hospitals depend on McKesson for economical and efficient management of their hospital pharmacies.

A McKesson representative will be glad to discuss your business problems with you—at no obligation. Why not let us send you the name of the McKesson Hospital Service Department nearest you. Address your inquiry to A. A. Mannino, McKesson & Robbins, 155 East 44th St., New York 17, N. Y.

oped to assure adequate personnel protection.

Emergency procedures may arise if a radium container is lost or a burst container releases radon gas and radium dust. In such cases, the following procedures should apply:

1. Notify all other persons in the room at once.
2. Vacate the room.
3. Close room and isolate from ventilating system.
4. Admit to the area only the minimum number of persons necessary to deal with the spill.
5. Confine the spill immediately.
   (a) Liquid spills:
   Don protective gloves and drop absorbent paper on spill.
   (b) Dry spills:
   Don protective gloves and dampen the spill thoroughly, taking care not to spread the contamination. Water generally may be used. Where chemical reaction with the water would generate an air contaminant, oil should be used for dampening.
6. Notify local and state health officials and the insurance carrier as soon as possible.
7. Decontaminate in accordance with plan agreed upon after a survey of the spill.
8. Monitor all persons involved in the spill and suggest methods for personnel decontamination.
9. Permit no person to resume work in the area until a radiation survey has been made.
10. Prepare a complete history of the accident and subsequent activity related thereto.

The entire radium handling program should be administered by one qualified person, preferably a radiologist or person having training in radiation or health physics. New personnel should be thoroughly indoctrinated in the potential hazards associated with radium use and receive instruction in safe handling procedures.

To insure adequate protection, periodic meetings should be held with all personnel involved to review methods of handling radium and safe practices for adequate protection. ■

NOTES AND COMMENT

Flu vaccinations urged for heart patients

A recommendation that persons with heart and blood vessel disease obtain vaccinations against influenza has been issued jointly by the American Heart Association and the U.S. Public Health Service.

In releasing the statement, Drs. Leroy Burney, surgeon general of the PHS and Francis L. Chamberlain, president of the heart association, said, "Influenza can be a real threat to persons with heart ailments. It is frequently a serious illness in this group and may result in death. We urge heart patients to seek the advice of their physicians with respect to obtaining the protection that vaccination will give."

The text of the joint statement follows:

"Experience has shown that patients with heart or lung diseases are more susceptible to the hazards of influenza than is the general population. This increased risk is shown by more severe illness and by higher case fatality rates among patients with these diseases. Patients with, or prone to, pulmonary congestion secondary to heart disease are an especially high risk group.

"Studies with influenzal vaccine have clearly shown that its use significantly reduces the incidence and probably the severity of influenzal infection, in the presence of local or widespread epidemics. Furthermore, use of the vaccine is contraindicated only in those patients who are allergic to the components of the vaccine. The type of local and systemic reactions to vaccine have not been such as to constitute any significant hazard to patients with cardiac disease.

"Therefore, the American Heart Association and the Public Health Service, through its National Heart Institute, wish to call these facts to the attention of all physicians throughout the country. It is further urged that persons with cardiovascular disease consult their physicians as to the advisability of obtaining influenzal vaccination." ■

'Staph' infection control topic of New York meeting

Main carriers of resistant staphylococci in operating rooms are members of the hospital staff themselves, a British physician declared recently in New York.

Dr. Robert Blowers, director of the public health laboratory at Middlesborough, England, speaking at the International Colloquium on Resistant Infections, said, "Every operation exposes a wound to the risk of air-borne infection, and the staff, who are the main carriers of pathogenic staphylococci in the operating room, do not always declare their lesions."

Among suggestions advanced by Dr. Blowers for controlling the spread of organisms in the operation room:

1. Remove reservoirs of pathogenic organisms, particularly unsterilized bedding and everyday clothing.

2. Limit movement in the operating room, thus reducing liberation and scattering of organisms.

3. Design special ventilating equipment to remove air-borne organisms.

4. Destroy air-borne organisms by ultraviolet irradiation.

Ruth B. Kundsin, Sc.D., bacteriologist at Peter Bent Brigham Hospital, Boston, said conventional mop and bucket methods of floor care have the effect of spreading a thin layer of organisms over the floor. Far better, she said, is the wet pickup technique in which the floor is flooded with a disinfectant-detergent. Dry mopping and dusting should be replaced by vacuum cleaning and wet dusting, she said.

Dr. R. A. Shooter, London bacteriologist, discussing the eradication of sources or resistant infection in hospital wards, recommended "proper aseptic nursing techniques, isolation of patients and other carriers infected with antibiotic-resistant staphylococci, and routine use of nasal creams and hexachlorophene soap for all patients. ■

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Suspension (125 mg./125,000 u per 5 cc.), 2 oz. bottles.
Pediatric Drops (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

References: 1. Cronk, G. A.; Naumann, D. E., and Casson, K.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia Inc. 1958, p. 397. 2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.: Antibiotics Annual 1954-1955, New York, Medical Encyclopedia Inc., 1955, p. 686.

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PATIENTS are evacuated by truck after all ambulances have been filled in this disaster drill, described in the accompanying article. The purchasing agent of the hospital with which the author is associated (Robert P. Troutman, man on truck facing camera) plays an important part in these drills.

THE PURCHASING AGENT AND NATIONAL DISASTER

by JOSEPH W. HINSLEY

EXERCISES in setting up the 200-bed emergency hospitals assembled and stored by the Office of Civil and Defense Mobilization figure large in preparedness for national disaster. Equipment above represents the hospital's central supply, sterilizing room and operating room.

An "it can't happen to us" attitude toward possible nuclear attack on the United States is wholly unrealistic in view of the tenor of international events, the author declares. He describes the grave effects of such an attack and outlines the role purchasing agents can play in forearming hospitals to meet the enormous demands that would be made of them.

DISCUSSIONS OF disaster planning usually make only brief reference to nuclear attack and its consequences. Many people, owing to their optimistic or religious beliefs, or to lack of interest, say "It couldn't happen to us." But today, as the world nervously watches the intercontinental missiles race and the fevered push to outer space, it seems only logical to place stress on the adequacy of our disaster planning in the face of nation-wide disaster.

With modern intercontinental weapons, we no longer can assume that possible future wars will be fought on foreign soil. Great losses in physical resources and population will occur in all countries engaged in a future global war. If an enemy sent over a wave of several thousand planes to the United States, 250 might hit the 144 target areas of this country. Casualty estimates given in this presentation are based on these assumptions.

According to latest figures,* the hospital field represents 6818 hospitals with 1,558,000 beds, an average census of 1,320,000 patients, and 1,401,000 employees. In the short-term general hospital there are 211 employees for each 100 patients, or slightly more than 2 employees per patient.

It has been estimated by civil defense officials that an all-out nuclear attack on this country would destroy one-third of our hospital beds. These are located in the 144 target areas or concentric zones of destruction.

Present estimates indicate that as high as 24 per cent hospital employees (along with all other civilians) would die during the first day following an attack and 38 per cent would be injured. We would have only one-third the

*Source: Guide Issue of HOSPITALS, J.A.H.A., Aug. 1, 1958 (Part II).

Joseph W. Hinsley is administrator of Lake Charles (La.) Memorial Hospital.

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For example, to conserve a patient's strength during surgery, operating room temperatures and humidities can be adjusted to suit the individual's condition. While convalescing, he gets the benefits of the exact temperature he finds most comfortable or the physician prescribes for his health.

By maintaining a consistently comfortable working environment, the Johnson System helps the staff to work at top efficiency. Likewise important, it gives nurses more time for their professional

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St. Vincent's Hospital, Green Bay, Wisconsin. Operated by the Sisters of the Third Order of St. Francis. Foeller, Schober, Berners, Safford & Jahn, architects and engineers; Selmer Co., general contractor, Brandemihl & Garot, Geo. F. Reeke Co. and Tweet Bros., mechanical contractors, all of Green Bay.

duties by eliminating time-consuming room temperature checks, unnecessary calls for service and endless trips to open and close windows.

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- **Lower Costs.** Pneumatic controls consume but a fraction of the power required by other types of controls. There is no planned obsolescence. Upkeep expense is nominal. With ordinary care, a Johnson System can be expected to last for the life of the building.
- **Complete Safety** . . . even in the presence of explosive anesthetic gases.
- **Reliable Performance.** Johnson Pneumatic Controls are unaffected by short circuits, electrical overloads, voltage variations and humidity. You get continuous, accurate control.
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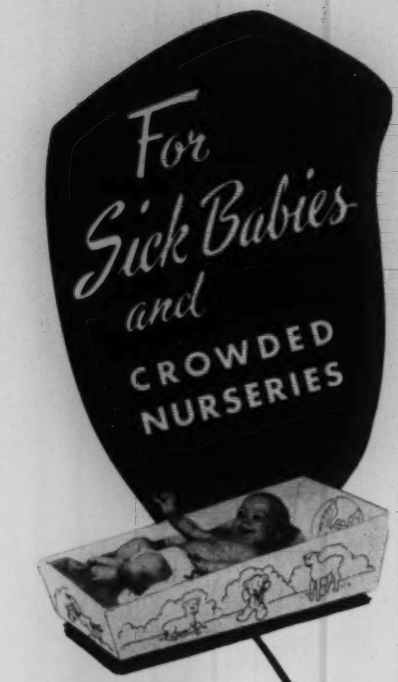

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BASIC DISASTER CHECK LIST FOR PURCHASING DEPARTMENT

No two emergencies present the same problems, and unforeseen necessities and deficiencies occur regardless of the best planning. The purchasing agent gains valuable insight into disaster needs as a member of the hospital's disaster planning committee. Comprehensive knowledge of the normal operation of the hospital, of normal supply needs for each department and abnormal needs under disaster conditions is essential.

Following are a few of the matters that require the attention of the purchasing agent when disaster threatens:

- Anticipate maintenance hazards with engineer.
- Order an auxiliary supply of fuel for emergency generators.
- Put in an extra supply of oxygen.
- Provide supplies to safeguard windows, doors and skylights (windstorm).
- Confirm standing orders for extra milk, bread and coffee, and check with dietary department on stocks of sandwich material, paper plates, cups and tableware.
- Anticipate supplies needed for immediate issuance to regular nursing stations, emergency rooms, temporary first-aid and receiving wards.
- Check supplies and equipment in disaster cupboards and replace stock necessary to bring them up to standard.
- Make sure that the casualty evaluation section is well supplied with emergency medical tags and short-stay medical forms, bags for patients' personal effects, and what will be used for disaster pouches if establishment of a morgue becomes necessary.

Under disaster conditions, there are many emergency decisions that rest with the purchasing agent, who must either furnish needed items or know of adequate substitutes. Some of his responsibilities:

- Confirm previous arrangement for emergency water supply.
- Check items of a strictly emergency nature, such as cots, litters, paper blankets, cups and tableware, and have them moved to the designated emergency areas.
- Confirm previous plans for alerting radio-equipped taxicabs and ambulances for help in moving ambulatory patients to their homes.
- Notify civil defense authorities of need for help in traffic and visitor control.

employees and two-thirds the number of regular hospital beds to care for 50 times as many patients. Many of these casualties would be located in areas that would be beyond immediate help, and a large percentage of the injured would die within 60 days.

The concept of postattack hospital care is a reversal of ordinary practice. We presently give first consideration to the most seriously injured, but in a postattack period first consideration would be protecting the health of noncasualties. Next would come first-aid and medical and surgical attention to the minimal (walking) casualties, to return them to the work force as soon as possible. Third would be care of children and women of child-bearing age, and last, care of nonambulatory casualties that reach medical facilities.

Medical supplies would be reserved to maintain the normal health of the uninjured, these demands being estimated at twice as much as usually used, due to the more strenuous working effort, reduced caloric intake and greater exposure to disease arising from lack of normal sanitation. It is estimated that contagious diseases would be 2½ times as prevalent as during normal times.

To augment the remaining hospital facilities following any major disaster, the Office of Civil and Defense Mobilization (formerly the Federal Civil Defense Administration) has provided and prepositioned more than 1900 emergency hospitals of 200-bed capacity. The value of these hospitals in a disaster depends upon the skill of responsible personnel in assembling and operating them. It is the duty of every purchasing agent to familiarize himself with the equipment and supplies in this emergency hospital and the meth-

od of obtaining additional supplies during an emergency.

Four times in 1958, Lake Charles Memorial Hospital set up and dismantled one of these emergency hospitals in locations 60, 80, and 220 miles from home, in addition to the local drill. This hospital, equipment and supplies for which are stored in two large vans, is used as part of the training program for disaster planning groups throughout Louisiana.

On each of these trips the purchasing agent was in charge of the convoy and of setting up the hospital. On these assignments he is assisted by an engineer, a male x-ray technician, a male laboratory technician, two male nurses, four porters (all personnel from Lake Charles Memorial Hospital), and whatever voluntary help can be made available by the local civil defense organization.

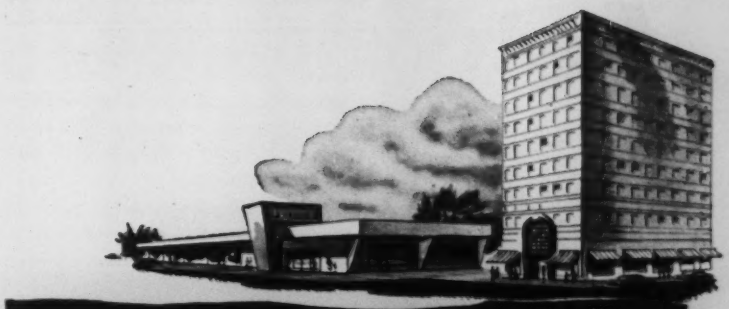
SETTING-UP EXERCISE

A good example of this drill occurred during the evacuation of the hospital on May 7, 1958, "Operation Alert Day". Emergency medical tags, based on the 7 a.m. condition sheet of patients, were made out for each patient. Information on these tags included the patient's name, diagnosis, method of transportation required if the hospital were evacuated, and other pertinent medical and social information for rapid identification. Student nurses from the local college where the hospital was to be set up played the roles of patients.

When the civil defense organization sounded the first alert approximately 2½ hours before zero hour, the purchasing agent and his assigned crew left immediately for the college gymnasium to set up the hospital. Ambulance companies were notified to send all available vehicles to the hospital, and the civil defense office sent trucks to take remaining patients and critical supplies to the college site. All patients had left the hospital within 22 minutes of the first alert.

The purchasing agent and the administrator are responsible for an annual inventory of this emergency hospital, with special attention being given to the expiration dates on drugs, antibiotics and x-ray films.

Our chief concern in planning



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for national disaster is with the potential resources before and after an attack. The problems involved indicate the need for preplanning and prompt establishment of operational procedures to manage a nation-wide health and welfare problem.

Medical Supplies. As a part of his responsibility to his hospital, the purchasing agent should take an active part in the local civil defense organization and become familiar with the stock of supplies and procedure for obtaining these supplies in the event of disaster. He should work with the supply committee of the local civil defense agency in accumulating each year an inventory of medical supplies in the community, including those in hospitals, drugstores, warehouses, wholesalers, manufacturers and health agencies. Each hospital, health, and civil defense agency in the community should be furnished with a copy showing item, quantity and location of each commodity.

EMERGENCY SUPPLIES MAINTAINED

The Office of Civil and Defense Mobilization maintains 43 regional warehouses containing some $250 million worth of supplies to be used by hospitals during an emergency. These supplies include electric generators, water pumps and tanks, and lightweight quick-connecting pipe to reach the source of a temporary water supply.

It is estimated that the medical supplies would be sufficient for 4¼ million casualties for three weeks. Stock piles of health and medical supplies and equipment are controlled by regional civil defense administrators. In time of disaster, requests for supplies and equipment are to be forwarded to the appropriate regional office when private sources are no longer available.

Blood Bank. The entire blood program during an emergency will be the responsibility of the American National Red Cross which, by agreement, is the designated collecting agency for the Office of Civil and Defense Mobilization.

Food. Estimates indicate that the average home has a six-day supply of food. This supply, added to the total in local retail stores, wholesale warehouses and cold storage plants, would make up enough to last the average community 28 days, it is estimated. Taking into account the casualties on the day of the attack and allowing 2000 calories per day per person, the food supply would last 42 days; allowing for the number of deaths during the first few weeks due to radiation or lack of medical care, the food should be sufficient to last the remaining population for 60 days.

Immediate action should be taken by the purchasing agent, dietitian and administrator in determining the hospital's food requirements on a 30-, 60- and 90-day basis, and also an inventory of food on hand. The requirements should be based on 2200 calories per person per day.

The purchasing agent should also determine the type of food immediately available, particularly that of a perishable nature. Conservation of food by the immediate use of perishable items should be practiced. Food inventories should be divided into six major categories:

1. Meat, poultry, eggs and fish
2. Milk (all forms)
3. Flour and cereals
4. Fruits and vegetables
5. Fats and oils, including butter, lard, shortening and cooking oils
6. Sugar and sweets

The food requirement for survival cannot be expressed in terms of specific items, except milk for small children. The daily diet should include at least one item in each of the six categories enumerated. Special food preparations should be reserved for those who require special diets, children under two years of age, pregnant women and nursing mothers.

In the event of a national disaster, the Emergency Food Agency will issue an order prohibiting the sale and use of food at any level except consumer level. This will apply to all food articles except perishable items such as milk, fresh fruits and vegetables, and fresh meat and poultry that would spoil if not issued for immediate use. A food requisitioning system and priority orders will be instituted, and food will be moved from surplus areas consistent with fall-

out conditions. Supplies issued by government agencies will depend upon availability and suitability.

The foregoing references to action following a national disaster are in conformity with the Basic Standards of Operating, issued in connection with Operation Alert 1958.

Communications. Hospitals must develop a communications system within their disaster plan. Plans have been made for the mobilization of all types of communication services and a procedure has been developed for urgent telephone calls and telegrams. Through a radio network hospitals would be able to maintain communications with each other and also with other local agencies. Lake Charles Memorial Hospital, for example, is part of a radio network linking the fire department, state and city police, a nearby air force base, the weather bureau, the civil defense agency, and all major industries within the area of Lake Charles. This hospital also maintains a radio advisory station for its heliport and an emergency medical channel for its vehicles.

The purchasing agent must know the precedence code for requesting long distance telephone service, telegraph or TWX service and what priority he can claim in placing orders for hospital material.

First priority will be given to messages reporting immediate danger due to the presence of the enemy. Second priority is reserved for reports of damage due to enemy action or major natural disaster. Third priority will cover most of the business of the purchasing agent. It is classified as:

1. Civil defense, the public health and safety.
2. Important government functions.
3. Maintenance of essential public services.
4. Urgent communications concerning production, procurement and distribution of food, essential materials and supplies.

Transportation. In an immediate postattack period, widespread devastation will have crippled all forms of transportation. State and local governments will assume charge in order to make maximum use of remaining local transpor-

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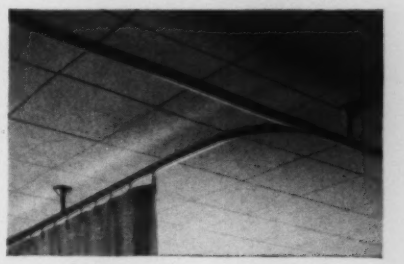

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tation resources and to supplement them with city, state and military vehicles. A priority code will be established by the local civil defense agency.

Manpower. The U. S. employment service, state employment services, or local employment agencies will be designated as the offices for the registration of existing and available manpower and as the source of the hospitals' supply.

SELF-HELP VITAL TO WELFARE

Self-help in the initial period after any disaster is vital to the health and welfare of the community. The mass displacement of people, conditions of crowding and unsatisfactory sanitation, and reduced caloric intake after a national disaster would greatly increase the incidence of communicable disease. The disruption of the power supply and the contamination of surface water supplies would seriously add to the sanitation problem after a National disaster.

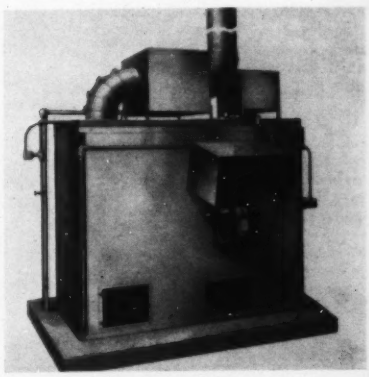
The purchasing agent will be among those called upon to assist governing officials in formulating policies for the allocation and distribution of food and medical supplies. From the experience of some of our number, we in the hospital field realize that all services during a major disaster must emanate from or become a part of government. Various civil defense divisions will operate with their counterpart in government. In the medical care field we must form a national health organization along military lines in order to make our services most effective. Civil defense emergency hospitals must be made an extension of the services U. S. hospitals owe their country. Hospital administrators should assist civil defense authorities in the pre-positioning of these hospitals and in organizing and training crews to man them. Every department head within the hospital should plan for an alternate to carry on his or her duties, or to be sent out to staff an emergency hospital. ■

equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

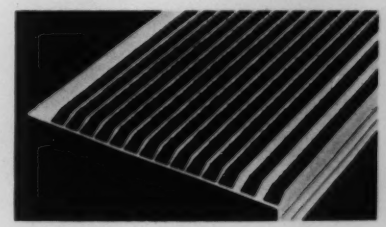
Incinerator (6D-1)

Manufacturer's description: Incinerator has an automatic lock on the feed door and a water wash in addition to multiple burners and combustion chambers. The feed door cannot be opened until the temperature in the secondary combustion chamber reaches a preset heat sufficient for maximum operating efficiency. The water wash captures any remaining fly ash and reduces smoke. A blower provides the right amount of up-draft through the water wash and greatly reduces chimney requirements. *Winnen Incinerator Co., Dept. H6, 932 Broadway, Bedford N-95, Ohio.*



Safety stair treads (6D-2)

Manufacturer's description: Heavy-duty aluminum safety stair treads have a flat abrasive surface that helps to prevent slipping and tripping. These rugged treads are distinctive in appearance and have passed



▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

_____ Incinerator (6D-1)
_____ Safety stair treads (6D-2)
_____ Microscope kit (6D-3)
_____ Laboratory equipment (6D-4)
_____ Bedside cabinet (6D-5)
_____ Laundry bags (6D-6)
_____ Emergency generator (6D-7)

PRODUCT LITERATURE

_____ Laboratory glassware (6DL-1)
_____ Drinking tubes (6DL-2)
_____ China (6DL-3)
_____ Gas cylinders (6DL-4)
_____ Metal radiation warning signs (6DL-5)
_____ Water Heater (6DL-6)
_____ O.R. caps and masks (6DL-7)
_____ Chain link fences (6DL-8)
_____ Clinical utensils and equipment (6DL-9)
_____ Metal letters and signs (6DL-10)
_____ Custom curtain walls (6DL-11)
_____ Emergency lighting equipment (6DL-12)
_____ Wall construction (6DL-13)
_____ Fire-protected ceiling system (6DL-14)
_____ Hot water boiler (6DL-15)

NAME and TITLE _____

HOSPITAL _____

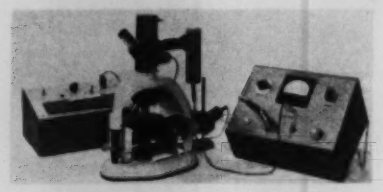
ADDRESS _____

(Please type or print in pencil)

severe oil and grease tests. *Wooster Products Inc., Dept. H6, M-R Division, 1000 Spruce St., Wooster, Ohio.*

Microscope kit (6D-3)

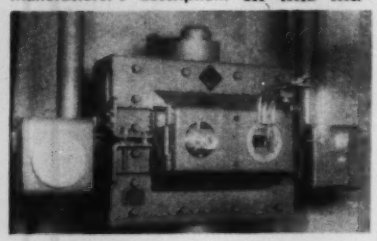
Manufacturer's description: Microscope kit consists of a block, lamp, and a combination exposure meter and shutter timer. They provide microprojection, photomicrography, cinematography, and semiautomatic exposure control for all standard makes of research-type light microscopes. Block contains monocular or binocular eyepiece, independently focusable projection lens, mount for plate or film



camera, and hand or solenoid-operated shutter. Observation, projection and photography of same specimen can proceed at the same time. The combination exposure meter and shutter timer is sensitive to 10-6 lumen, and provides push-button control of camera exposures from 0.1 second up to one full minute. *Canal Industrial Corp., Dept. H6, 4940 St. Elmo Ave., Bethesda 14, Md.*

Laboratory equipment (6D-4)

Manufacturer's description: In this machine, the combining of the electron-producing and x-ray-producing functions in a single tube simplifies betatron operation and reduces patient set-up time. Previously, certain types of deep therapy necessitated changeover to a special electron tube. This is eliminated with the electron beam and the x-rays originating at opposite sides of the tube so that the exit ports are spaced apart on the front of the betatron. The straight forward beam paths simplify patient positioning and decrease the distance the beams travel. *Allis-Chalmers Manufacturing Co., Dept. H6, Milwaukee 1, Wisc.*



Bedside cabinet (6D-5)

Manufacturer's description: Bedside cabinet stands lengthwise along bed, is 6 in. narrower and 6 in. longer than conventional cabinets. Drawer has lock with separate master key for each nursing unit. Compartments are completely separate

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units, permitting cabinet to be used for two patients when space is at a premium. There are drawers at each end of the cabinet and sliding doors with adjustable shelves on each side. *Hospital Supply and Development Co., Dept. H6, 3109 Forbes Ave., Pittsburgh 13, Pa.*

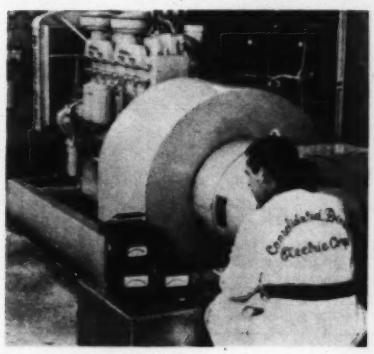
Laundry bags (6D-6)

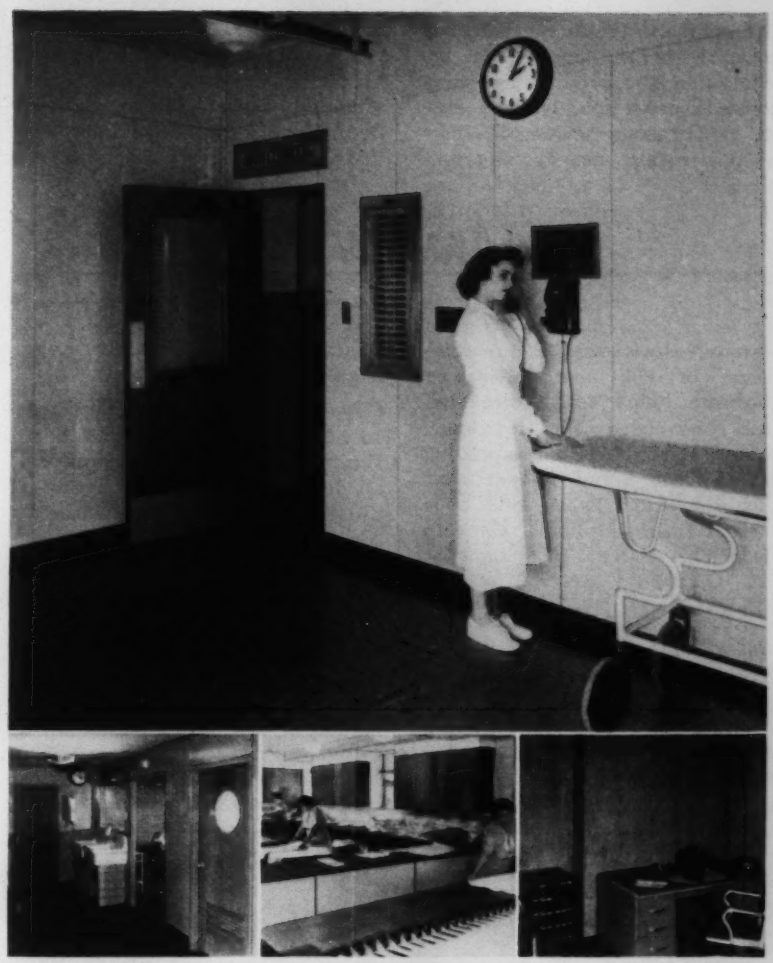
Manufacturer's description: Laundry bags with rope closures are equipped with a self-locking device that speeds and simplifies opening and closing, eliminating the need for untying or cutting knots. The bags are equipped with strong nylon rope with the self-lock attached. To close, the self-lock is slid for-

ward where it automatically locks in position, providing a secure closure that cannot come loose even under the roughest handling or washing conditions. To open the bag, a slight pull on the finger ring releases the self-lock. *The Hartford Co., Dept. H6, 21 Thomas St., E. Hartford, Conn.*

Emergency generator (6D-7)

Manufacturer's description: Standby emergency generator restores power in 1.5 milliseconds in the event of failure of commercial line power, thus eliminating the time that may be consumed in restarting and warming up. The unit consists essentially of synchronous dynamo, a flywheel, a magnetic clutch, a diesel engine and associ-





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ated controls. While normal line power is being supplied to an installation, the dynamo acts as a motor to drive the flywheel and as a synchronous condenser. When the power fails, the dynamo immediately acts as a generator. Inertia of the flywheel is applied in starting the diesel engine. *Consolidated Diesel Electric Corp., Dept. H6, 880 Canal St., Stamford, Conn.*

product literature

SEE COUPON, PAGE 93

Laboratory glassware (6DL-1)—Catalogue of 900 new laboratory glassware items, fully illustrated and color-coded for reference. Covers Pyrex brand laboratory ware, Vycor brand 96 per cent silica laboratory ware, and over 700 custom-made items. *Corning Glass Works, Dept. HL6, Laboratory Glassware Sales, Corning, N.Y.*

Drinking tubes (6DL-2)—Folder describes plastic drinking tubes that cannot collapse and will not soften when immersed for long periods in warm or cold liquids. They are easily sterilized and will not shatter. *Anchor Plastics Co., Dept. HL6, 36-36 36th St., Long Island City 6, N.Y.*

China (6DL-3)—Leaflet illustrates 16 stock patterns of china in a variety of shapes and decorations, all designed to meet the needs of the hospital food service operation. Also illustrated are two patterns in a square shape. *Syracuse China, Dept. HL6, 1806 West Fayette St., Syracuse, N.Y.*

Gas cylinders (6DL-4)—Bulletin on high-pressure gas cylinders for oxygen and medical gases. Information is also given on range of cylinder sizes, capacities and ICC specifications, and the weight-saving value of seamless cold-drawn cylinders. *Pressed Steel Tank Co., Dept. HL6, 1445 S. 66th St., Milwaukee 14, Wis.*

Metal radiation warning signs (6DL-5)—Bulletin on metal radiation warning signs that are weatherproof and heat-resistant, with lifetime porcelain enamel finish. Signs are available in a magenta and yellow combination, and are said to withstand intense heat. *Atomic Accessories Inc., Dept. HL6, 244-02 Jamaica Ave., Bellerose 26, N.Y.*

Water heater (6DL-6)—Folder describes automatic storage water heaters for hospital kitchens serving up to 6000 meals a day. Used without a booster water heater, this heater combines a two-temperature service, fast recovery and high stored water temperature. *Columbia Pipe and Supply Co., Dept. HL6, 1120 W. Pershing Rd., Chicago 9, Ill.*

O.R. caps and masks (6DL-7)—Illustrated price list shows a complete line of operating room caps and masks for nurses and surgeons that are made of lightweight muslin, preshrunk to withstand re-

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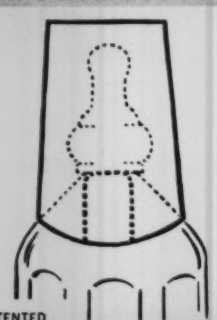

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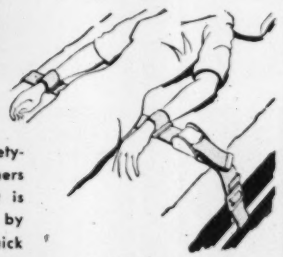

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peated launderings. *Acme Cotton Products Co., Inc., Dept. HL6, 245 Fifth Ave., New York 16, N.Y.*

Chain link fences (6DL-8)—Folder on aluminized chain link fence fabric gives styles, gauges, construction features, heights, etc., and typical installation photographs. *American Chain & Cable Co., Dept. HL6, 929 Connecticut Ave., Bridgeport 2, Conn.*

Clinical utensils and equipment (6DL-9)—Catalogue features an instantaneous hot pack and compress steamer. Also shown is a line of basins, dressing jars, bedside pitchers and trays, feeding cups, tumblers, powder cans, vinyl trays, and bed trays. *Wear-Ever Aluminum, Inc., Dept. HL6, Wear-Ever Bldg., New Kensington, Pa.*

Metal letters and signs (6DL-10)—Color brochure presents a variety of metal letters, plaques and symbols in permanent weatherproof bronze, nickel-silver, aluminum, stainless steel and brass. Also special plaques made from drawings, models, trademarks and other reproductions. *A. J. Bayer Co., Dept. HL6, 2300 E. Slauson Ave., Los Angeles 58, Calif.*

Custom curtain walls (6DL-11)—Catalogue discusses three series of curtain walls that are adaptable to all architectural treatments. The three types are: typical sections for large flat panels, designed for enclosure of medium and high-rise structures; light commercial grid for multi-story buildings; and structural aluminum grid, for low-rise buildings. *Albro Metal Products Corp., Dept. HL6, 944 Longfellow Ave., New York 59, N.Y.*

Emergency lighting equipment (6DL-12)—Catalogue of automatic emergency lighting equipment operated without switches or timers. Trickle and high rate charge is automatic, thus lowering maintenance to a minimum. *Electric Cord Co., Dept. HL6, 21 Spruce St., New York 38, N.Y.*

Wall construction (6DL-13)—Catalogue describes floor-to-ceiling structural systems to speed and simplify construction and erection of interior walls and partitions. Structural uprights are all-steel welded construction for maximum strength and slotted to accommodate shelf brackets, cross bars, and other hardware. *Reflector Hardware Corp., Dept. HL6, 1400 North 25th Ave., Melrose Park, Ill.*

Fire-protected ceiling system (6DL-14)—Illustrated booklet on acoustical tile ceiling material designed to provide effective fire protection for structural steel members and the floor or roof assembly under which it is installed. *Armstrong Information Service, Dept. HL6, Lancaster, Pa.*

Hot water boiler (6DL-15)—Bulletin uses tables, charts and photographs to explain the operation of a hot water boiler designed for forced circulation hot water systems. The bulletin also explains the internal boiler water circulation arrangement which permits the hot water boiler to withstand three times its rated capacity in terms of thermal shock. *Orr and Sembower, Inc., Dept. HL6, Reading, Pa.*

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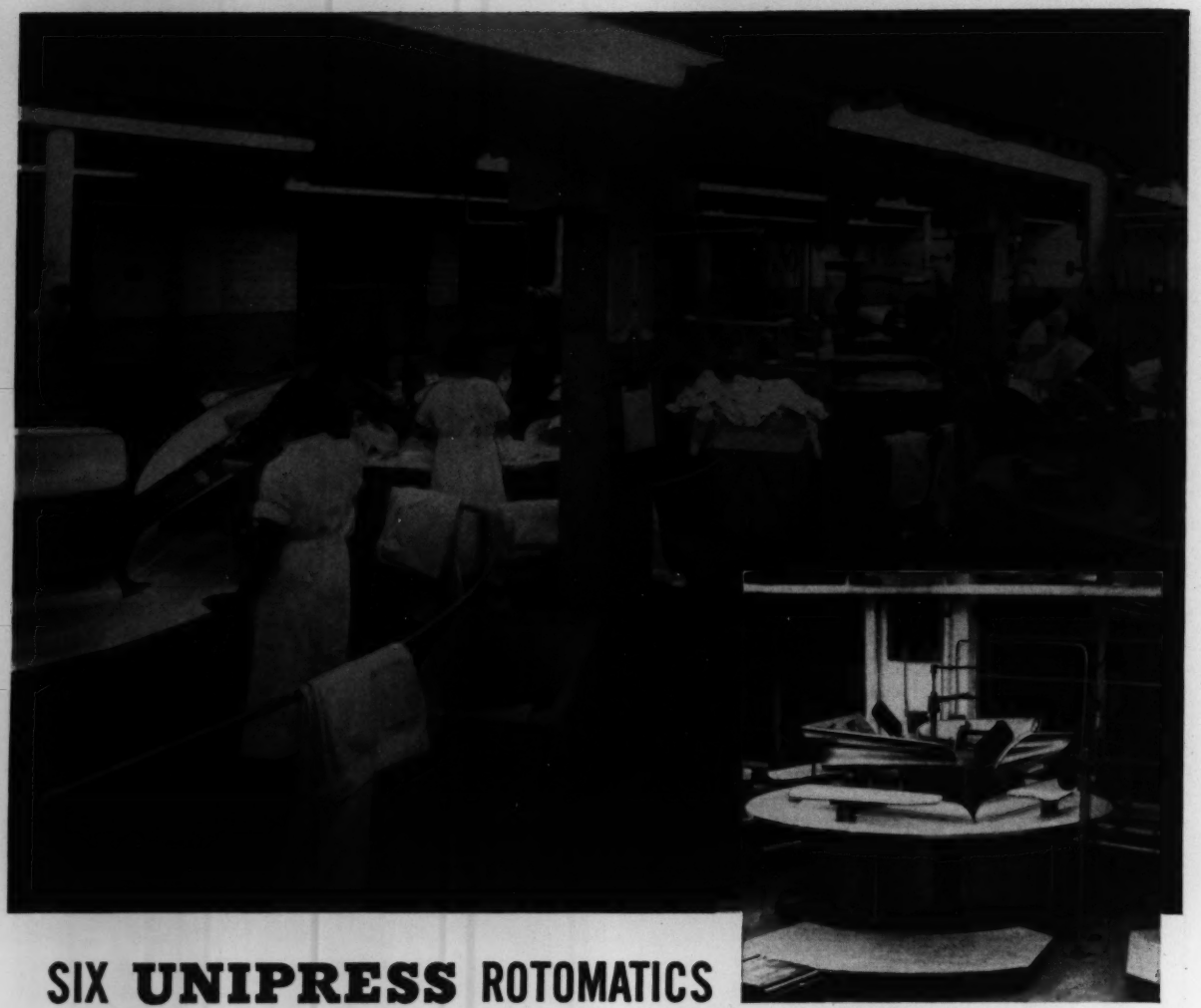

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HOW A LAUNDRY METHODS STUDY RAISED PRODUCTIVITY 70 PER CENT

by CHAIM ASCHHEIM

How a systematic analysis of laundry procedures increased laundry productivity 70 per cent and brought about an even greater gain in equipment output is described by the administrator of a hospital in Israel. Employee flexibility, it is noted, was a major factor in the achievement of these results.

As PART of Malben Hospital's over-all productivity drive, linen requirements and laundry performance were closely analyzed. This analysis and resulting implementation of a six-step efficiency program have increased general laundry productivity at the hospital by approximately 70 per cent. Expenditure for the laundry is, today, completely offset by income from contract work done for other hospitals.

The program began when the hospital's laundry manager enrolled in an evening course for foremen. Then, in close cooperation with the nursing division, we made a study of linen requirements, establishing optimum weekly quantities. Much thought was given to the proper hours of delivery—having linen arrive at the nursing unit when the staff could devote some time for exchange of soiled for clean linen; and ensuring an equalized daily load for the laundry to avoid additional manpower requirements for peak loads, etc.

We next called in a firm of efficiency consultants* asking them to carry out investigations of work flow, time studies, etc., keeping in view the studies carried out by the American Hospital Association, as published in the AHA publication, *Hospital Laundry, Manual of Operation.*

SIX CHANGES RECOMMENDED

As a result of this investigation the following changes were recommended:

1. Floor area and layout.

The first step was to analyze the layout of the laundry in relation to the flow of work. After initial studies, it was found that a few minor changes in the position of the receiving department (dirty laundry) and the shipping department (clean laundry) would save considerable time and work. The room for repair of torn laundry was moved closer to the finishing sections of the plant. The office of the foreman was positioned so that he would be able to observe the entire laundry. This change also made it unnecessary to walk through the laundry to reach the foreman.

These adaptations helped rationalize the flow lines of the laundry without expensive alterations in installations or machine positions.

2. The washing cycle.

Next, a study of the washing technique was made. The laundry is equipped with one 331-pound washing machine, and two smaller 110-pound washing machines—giving a total capacity of 551 pounds per washing cycle. A single operator handled all three machines including loading and unloading. One standard process was used throughout, no distinction being made between various soil classifications. A normal washing cycle lasted between 95 and 105 minutes.

A thorough investigation of optimum methods and cycle times for various soil classifications was carried out in this manner. As a result of these investigations, two standard methods were evolved, one for medium and the other for heavily soiled articles. The total times per washing cycle were reduced to 60 and 68 minutes, respectively. This includes loading, unloading and other operating elements. At the same time, it was found advisable to reduce the loading of the machines to achieve stronger battering action of the water in the rotating drum.

3. Extraction.

Two extractors, one with a dry capacity of 165 pounds and the other with a capacity of 66 pounds, were operated by a second man. He also did the sorting after extraction for the finishing phases (flatwork ironer) and was responsible for operation of three fluff-drying tumblers, each with a capacity of 44 pounds. Four hand-operated tank trucks were available for transport of laundry from washing machines to extractors.

Heretofore, extraction had proved one of the most serious bottlenecks. Due to lack of coordination between washing and extraction, the four trucks were often waiting fully loaded for prolonged periods, while washing machines could not be unloaded.

To overcome these difficulties, it was decided to regard washing and extraction as one unified activity and to combine the duties of the two operators, thus forming a fully coordinated two-man crew. It was no longer necessary to

*Erteschik, Gelbard & Associates, Ltd., Tel Aviv, Israel.

Chaim Aschheim is administrator, Malben Chest Hospital, Beer Yaacob, Israel.

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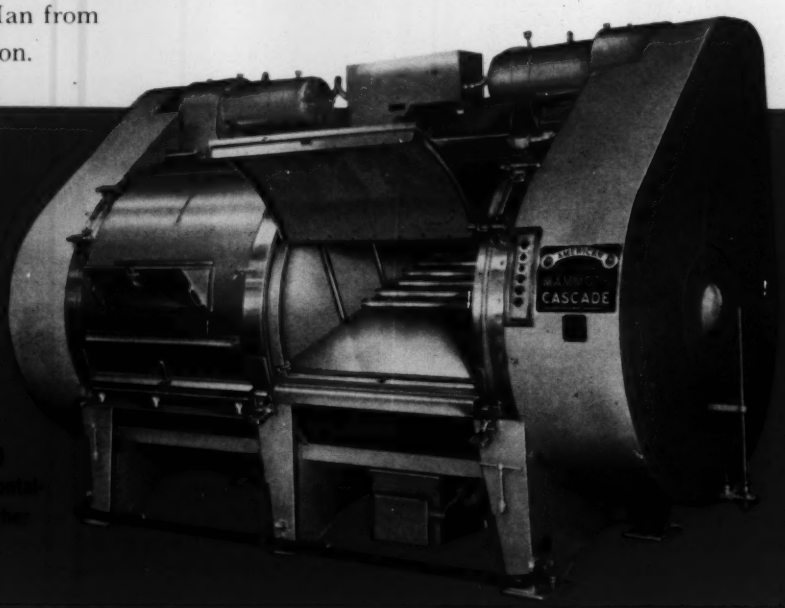

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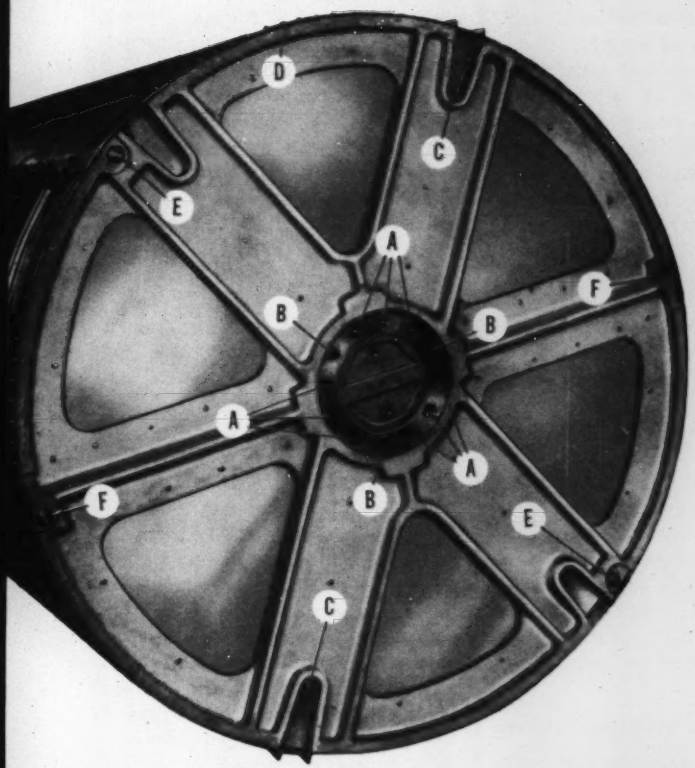

Cylinder gudgeons are press-fitted to transmitters, and held fast by 9 bolts at (A), and 3 precision-ground, drive-fitted dowel pins at (B).

Full-length 6" ribs (C), .109" thick, extend through cylinder end sheets and are riveted to transmitters.

Cylinder side sheets, .109" thick, extend over and are riveted to flanges (D) of transmitters.

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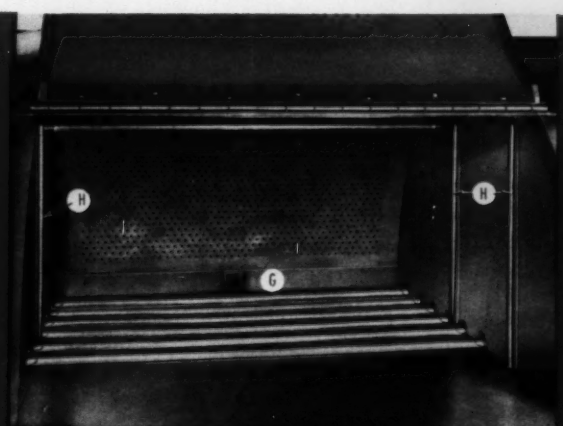
Full length 3 x 3 x ¼" stainless steel angles are bolted to cylinder end heads and transmitters with body-fit bolts (F). The angles are also welded to horizontal partition, cylinder side sheets and vertical partitions (G) (below).



Vertical partitions .109" thick, have two reinforcing bands (H) welded to each side.

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operate all the washing machines since, with the improved methods, two machines could now do the work previously done by three. Thus, the output of the washing machines could be closely matched to that of the extractors. The cycle time per extraction was increased from 20 to 30 minutes and two extraction cycles were run for each washing cycle.

4. Flatwork ironer.

To achieve better performance from the flatwork ironer—a four-roll model with four electrically adjusted speeds—a series of tests was performed to determine the feasibility of passing such double-lined items as pillow cases only once. It was found that if the speed of the mangle were reduced to 10 feet per minute, the desired result could be achieved. The reduction was achieved simply by reducing the diameter of one of the belt transmission wheels. This modification had the effect of decreasing all four speed positions by about 20 per cent. The former high-speed position of 45 feet per minute was found to be of little practical value, and could be dispensed with.

Work standards laid down for the flatwork ironer were all based on a four-man crew, two at the feeding end and two at the receiving end. The men at the receiving end also did the folding. For some types of work, such as pillow cases, it is found practical to work with a three man crew—one feeder and two receivers.

5. Presses.

Equipment in this section includes one rotary press, two small standard presses for trouser tops, three larger standard presses and a sleever. Three press operators ordinarily were on duty. This complement was found to be excessive, however. After rearrangement, the work crew was reduced to two operators. Although this arrangement lengthened the elapsed times for certain articles, the overall productivity per operator was appreciably increased.

6. Estimate of required man and machine hours.

Determination of manpower requirements for various levels of output is, of course, dependent on the total volume and composition of incoming linen on the one hand, and the man and machine hours required for the processing of each article on the other. The latter having been established on the basis of work and time studies, it was then necessary to make an analysis of the composition of laundry for various volumes and different sources of supply.

To this end, a special daily form was developed in which all incoming articles were recorded according to source of supply. Articles were grouped together according to which finishing process they needed—ironing (flatwork), pressing, fluff drying or folding. Also, the soiled weight per quantity of each article was recorded and summarized per finishing group and per daily total.

The results obtained over a sufficiently long period were analyzed and estimates of man and machine hours were calculated against expected quantities of individual items for any given volume of incoming laundry. The quantitative parameter used for washing, extracting and fluff drying was based on weight. That for the flatwork ironing, pressing and folding was based on numerical quantities.

INCREASED FLEXIBILITY RESULTS

Putting this six-step program into effect at Malben Chest Hospital has resulted in several advantages:

Flexibility—The machine or elapsed hours at individual stations are less than the hours of a normal working day for practically all levels of output. To ensure rational employment and a satisfactory level of productivity it became necessary to attain a high degree of operator flexibility. Every crew had to be able to perform any phase of the laundering process from washing to folding.

The flexibility thus achieved led to an arrangement whereby crews are kept mobile by moving them from one station to the next as required. For example, after completing a daily quota, the two-man crew operating the washing machines, extractors and drying tumblers move on to the flatwork ironer.

The other two operators making up the four-man crew that operates the flatwork ironer would have been previously employed at the presses and at the folding table.

Such a flexible working program obviously could result in considerable savings if successfully implemented. Wage agreements in public institutions in Israel, however, do not allow for piece rates, premiums or other monetary incentives. Also, it was quite clear to the laundry operators that implementation of the new methods could only result in some of them being laid off, as there was no point in increasing the supply of linen to the hospital.

To overcome these two psychologically retarding factors, especially the latter, some operators were transferred to other departments of the hospital. We also entered into negotiations to do contract work for several other hospitals.

Productivity—At a relatively low rate of turn-over it is not always possible to balance man and machine hours to conform to theoretically calculated estimates. Nevertheless, the actual results achieved in the laundry have been very encouraging. During the first four weeks after implementation of the new operating plan, the general level of productivity rose from an average of 15 pounds per man hour to 25 pounds per man hour—or approximately 70 per cent.

Of particular significance were the results obtained from the washing machines. According to previous data, the three washing machines had processed on the average 234 pounds per hour. With the improved methods, and using only two machines, the average hourly production rose to 304 pounds per hour.

Balanced budget—Since October 1957, when we started to operate at the new production level, all direct costs such as manpower and materials have remained unchanged, and are completely covered by the income from contract work from four other hospitals. Through an economy campaign and some alterations in the boiler room, we succeeded in keeping the requirements for water, electricity and fuel unchanged, in spite of increased output levels.

In other words, the whole expenditure for the hospital laundry is today completely offset by income. ■

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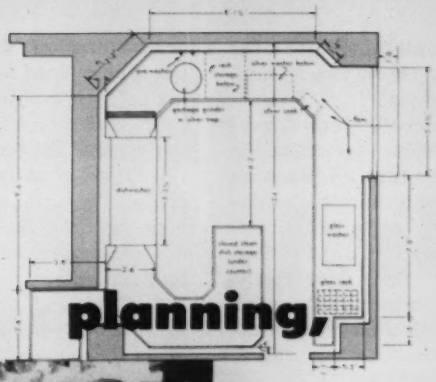

by RUTH GORDON

This article is a brief guide to the planning, equipping and staffing of a food service facility in any size hospital. The author lists the general factors that must be considered, areas of activity that must be planned for, and the kinds of equipment needed in each unit of a hospital food service department.

IN ANY DISCUSSION of food service programing, the following six elements must be considered:

1. Factors used in determining types of food service.
2. Estimating equipment and staffing requirements.
3. Methods of serving and distributing food to patients.
4. Planning the kitchen and related facilities.
5. Receipt, refrigeration and storage of food.
6. Equipment selection and layout.

Before discussing these points in detail, it is necessary to define the functions of a dietetics and nutrition department.

1. *Administrative.* This entails the efficient management of general food service and includes selection, purchasing, preparation and distribution of the highest quality food in order to maintain health for the convalescing patient and for personnel.

2. *Therapeutic.* This function of the dietetics and nutrition department is the interpretation of the doctor's prescription to meet the nutritional needs of a patient or the scientific diet of a patient.

3. *Educational.* This function includes distribution of scientific information concerning food and its effect on the body to the patient (inpatient and outpatient), medical student, dentist, nurse, dietetic intern, social worker, and personnel.

4. *Research.* The department's research function includes the critical study, experimentation, and investigation of foods and their effect on the human body.

Each hospital in planning its food service should set up these four functions for its dietetics and nutrition department, regardless of its size. One dietitian performs all four functions or, if there are two dietitians, they divide them.

The important point is that these responsibilities should be assigned to and belong to hospital food service.

When one considers how diversified these four functions are, it is easy to see that much time is required for the successful *planning* and *efficient* organization of such a department. Everyone is extremely busy and time is precious, but any department that spends the amount of money that the dietetics and nutrition department does will receive rich dividends in the long run for the time that it devotes now to planning. In a new building or a remodeling project, hospital food service personnel should be given enough time to live, eat and sleep the planning and organizing.

At the University of Kansas Medical Center, the administrator, architect, and the food service staff spent five years planning the department, two years building and, to date, we have spent five years trying to make it run.

We have not made one change from the original plan and gradually we are achieving a smoothly run organization. We firmly believe the hours upon hours spent have rewarded us well.

SELECTION OF STAFF

After determining functions, the next step is the selection of the person who is professionally competent to give the kind of leadership that will conform to the highest business standard and practices and, at the same time, conform to practices of the other professional groups within the hospital. The selection must be made carefully on the basis of education, training, experience, person-

Ruth Gordon is director of dietetics and nutrition at the University of Kansas Medical Center, Kansas City. This article is adapted from the author's address at the American Hospital Association Institute on Planning and Operation in Louisville, February 1958.

ality and adaptability for the unique type of food service so necessary in a hospital.

The appointment of such a person should be made so soon as the budget allows so that all planning and policy-making within the department can be done jointly between administration and the food service director. Successful operation requires continuity. To effect this means long-term key appointments, if possible.

Continuous turnover in the position of food service director should be a warning that the understanding of the position may not be satisfactory to the dietetics profession. Primarily this means the position may not encompass the four functions of the department.

Once a food service director is selected, there are certain policies that the director must determine with the administrator of the hospital. These policies include:

1. Use of a selective or nonselective menu.
2. Foods to be allowed on standard hospital diets.
3. Policies concerning the serving of nourishments.
4. Type of and schedule for tray service.
5. Fixing the responsibility for tray service.
6. Whether to serve guest trays.
7. Procedures for handling complaints.
8. Type of food service for personnel—whether cafeteria or dining rooms, pay or nonpay.
9. Meals for physicians, private duty nurses, volunteer workers.
10. Method of determining meal census for patients and personnel.
11. Policies for employees—pay day, laundry, lockers, sick leave, holidays, uniforms, physical examinations, etc.
12. Staffing of the department.
13. Methods of purchasing, receiving and storing foods.

Frequently, joint conferences with other department heads are most valuable in determining procedures in the food service department. These conferences should be used, because there is no other department (except maintenance) that is so directly involved with all people in the hospital.

The first big task in food service programing is determination of the type of food service to be used for patients and personnel.

The following factors determine the type of service used:

1. Type of patient—whether indigent, private, combination of both, and the percentage of each; the percentage of bed to ambulatory patients.
2. Kind and size of hospital—private, government, university; general or specialized, such as maternity and chronic disease.
3. Location of hospital—resources in finding personnel; competition for the labor market; resources for supplies.
4. Budget—quality food means quality merchandise. All too often the budget is not compatible with the type of food service desired. They must be in harmony.
5. The degree of organization—whether highly organized or moderately so.

LOCATION OF DEPARTMENT

As soon as type of food service is chosen, the location of the dietary department within the hospital must be fixed. The factors influencing location are:

1. Accessibility to patient areas. This means the food service must be centrally located in order to give the best type of service.
2. Accessibility of dining room to main corridors, elevators, stairways, offices, classrooms, etc.
3. Accessibility to service entrance for delivery of supplies.
4. Accessibility to central storeroom.
5. The importance of aesthetics in food service as a morale builder. The location of personnel dining areas will be determined by the value placed on aesthetics.

With the decisions made concerning the location, the kind of food service desired, the amount of the budget available, the type of menu and the number of persons to be served, the next step is the floor plan.

A floor plan demands serious attention to scientific facts, experience and keen observation, and application to the given situation. The floor plan must provide adequate facilities for present activities and regard for future growth and development of the department.

The plan must mirror the problems involved in quality food production and service, which in turn, demands an understanding of the logical flow of food and work. All too often, more emphasis is placed on structural problems, such as a handsome entrance rather than on efficient operation and sanitation. Some of the shocking results in the medical center's dietetics and nutrition department have been due to our inability to consider the building in the light of functional requirements. The plan should be a pleasing balance of beauty and utility, one that incorporates colorful, easily cleaned walls and floors; modern lighting; air conditioning; acoustical walls and ceilings; and comfortable and adjustable working heights.

Adequate safety and sanitation must also be considered in preparing the floor plan. Many falls, slips and trips can be prevented by sufficient lighting, selection of nonslippery floors, use of ramps and elevators, keeping passageways clear of debris, and using conspicuous signs in hazardous places.

Much strain can be avoided by use of carefully planned working arrangements, proper storage heights, wheeled carts, and conveyors.

Gouged walls may be avoided by use of tile, well lighted, wide traffic aisles, double doors, photoelectric cells for doors for loaded trucks, glass inserts in doors, heavy and tight door checks, and by the elimination of cross-traffic in food flow.

Proper racks for storage of cutlery and guards on mechanical equipment will help reduce lacerations and other injuries to employees. Floor plans must provide adequate space for all activities. The activities to be included are: receiving, storage, pre-preparation, refrigeration, cooking, salad and sandwich preparation, baked goods and dessert preparation, pot and utensil washing, preparation of nourishments and modified foods, truck and cart storage, dining room or cafeteria, dishwashing, research, offices, conference area and classrooms.

Before discussing the design of specific units of floor plans, there are a few general statements

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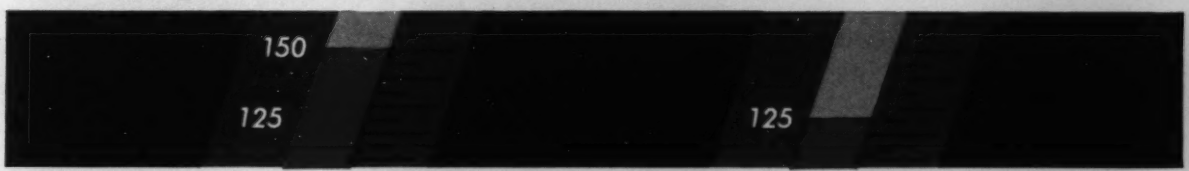

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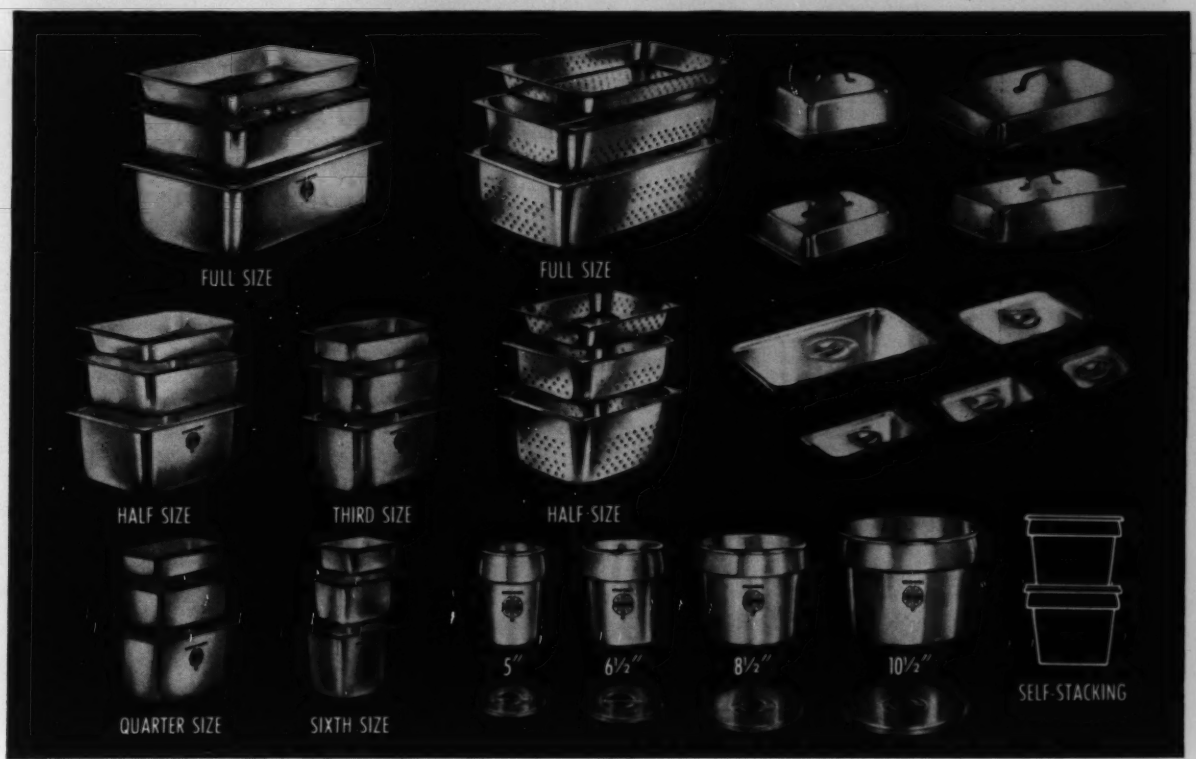

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which should be kept in mind when working out floor plans and planning equipment.

1. Amount of space needed must be determined by each individual hospital. There is no rule of thumb which can be given.

2. Food flow should be kept in proper sequence from the time it is received until it reaches patients and personnel. Food flow can be determined by drawing charts.

3. The use of island arrangement of equipment should be explored. If equipment is installed on the wall, it is necessary to set it out 18 to 24 inches to allow for cleaning.

4. Wherever possible, equipment should be portable.

5. Food production areas in a hospital are much larger in relation to the dining area than in a commercial installation because only approximately half of hospital food is served in dining areas. The extra space is needed for preparation, distribution and the additional variety of food needed for patient service.

6. Careful consideration should be given to the advisability of planning an "all electric" or an "all gas" food production area. There are such things as power failures and strikes.

7. Processing areas should be planned so that food is handled only once.

8. In the light of growing needs, deep freeze refrigeration should be provided.

9. Intercommunication system used.

Some of the more specific directives to keep in mind in planning are as follows:

- Main traffic aisles should be at least five feet wide.
- Aisle between work table and equipment should be at least three feet wide.
- Aisle in front of oven needs to be 3½ to 4 feet wide.
- Work heights are usually 36 to 38 inches. These should be adjustable, if possible.
- Working space for each employee is based on four linear feet per employee, except in the bakery unit, where there is need for five to six linear feet per employee should be provided.

Drinking water and hand washing facilities should be at convenient locations.

- Dietitians' offices should be located in areas they service. For example, the receiving office should be in the receiving area, the food production office in food production, dietitians serving patients in patient areas, etc. The director's office should be accessible to other administrative personnel yet close to the area of food service.
- Dining area should be adjacent to food production area.
- Provision must be made for floor drains, steam and water hose outlets with consideration given to strategic locations for cleaning purposes.
- Use as much stainless steel as the budget allows. The initial cost is greater but it is soon offset by durability and easy upkeep.
- Refrigerated space needs are generally based on 1½ to 2 cubic feet per meal served per day.
- Use of permanent bases for equipment should be considered.
- As many automatic, labor-saving and precision types of equipment should be used as budget and space will permit.

RECEIVING AND STORAGE AREAS

The outside platform should be covered. The height of the platform should be that of standard trucks above the driveway. The floor of the platform should be on the same level as the entrance to the building. The minimum width of the platform is 8 to 10 feet, with the length depending on the number of trucks unloading at the same time.

The receiving area must house hand trucks, portable racks, scales, desks, table, the quantity of food which is delivered at one time, and some space for storage of exchange items, such as milk cans.

Storage areas are located as close to the receiving area as possible. They should also be accessible to the pre-preparation unit. The storage area must house canned goods, grocery items, cleaning supplies, paper goods, china, glass, and linens. Metal shelving, metal storage bins, and wooden platforms are required for the storage of these items.

The storage area must be cool, well-ventilated, and moisture-proof. The floors should be washable and the windows, screened.

The space required for storage depends on the number of deliveries and how food is purchased. The trend seems to be towards less space with more frequent deliveries.

PRE-PREPARATION UNIT

The trend in pre-preparation or vegetable preparation is for less space and fewer pieces of large equipment, such as potato peelers, meat grinding machines, etc. The greater use of prefabricated meats, fish and poultry, and frozen fruits and vegetables has brought about this change.

The pre-preparation unit may be located adjacent to the cooking and salad area or it may be a part of the receiving and control areas. The equipment needed in the pre-preparation unit includes work tables, one of which should be low enough for employees to sit and work comfortably; sinks; small potato peelers; food chopper; cutting boards; and a large garbage disposer.

The walk-in refrigerators, which store meat, fish, eggs, butter, fruit and vegetables, are located in this unit.

Portable shelves or racks are needed for these refrigerators. Use of portable racks means food is handled once. When food is received, it can be placed on racks, wheeled into the refrigerators and left there until it is removed for cooking. The use of the deep or quick-freeze refrigerators is relatively new and the space given to it is increasing due to popularity of frozen foods.

COOKING UNIT

The main cooking area is usually in the center of the food production area and is located close to the pre-preparation, storage, container-washing and serving units. Placement of the cooking area in the middle with patient service on one side and cafeteria on the other side eliminates cross-traffic.

Equipment used in the cooking unit includes sinks, bain-maries or hot water baths, ranges, ovens, broilers, fryers, steam-jacketed kettles, pressure steamers, trunnion kettles, reach-in refrigerators, work tables with overhead racks, mixing machine, container racks,

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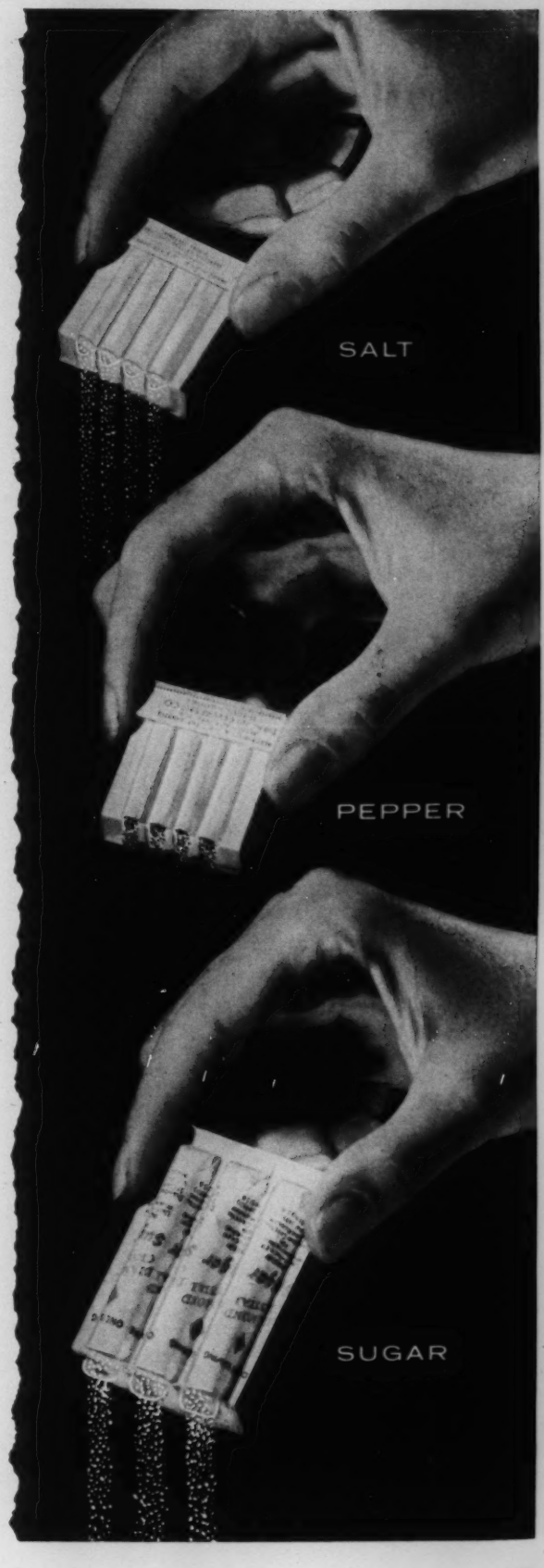

portable work tables, meat slicers and garbage disposals. The trend is to use smaller mixers and mix more often, to use fewer ovens and stoves but to cook constantly so that food is fresh and of better quality. The important point is that the kind and variety of menu used determines the kind and amount of equipment one buys.

Cooking containers should be purchased in modular sizes. This means that all equipment would be selected on the basis of uniform size so that a specified size of tray, rack or pan will fit the related refrigerators, ovens, shelves and trucks in an orderly manner. They are usually based on standard steam table pan (12 by 20 in.) for hot items and a standard bun pan (17 by 26 in.) for cold items. Refrigerator shelving is, of course, based on the same size.

If a modular size is followed, food handling is cut considerably. Pieces of equipment and related pieces may be arranged side by side in a straight line or back to back or facing in parallel lines. Hoods with sufficient exhaust fans for carrying away odors and heat should extend at least one foot over all cooking areas.

SALAD AND SANDWICH AREA

This area should be located close to the serving areas. Equipment in this area should consist of tables, sinks, refrigerators, refrigerated work tables, table model vegetable chopper and mixer, garbage disposer, mixing bowl and stand, and cutting boards.

BAKERY AND DESSERT AREA

The bakery and dessert unit usually operates somewhat independently of the others; therefore, it need not have direct association with other areas. It is helpful, however, if this unit can be located close to serving areas. Equipment needed for the bakery and dessert includes a baker's table, bins, spice boxes, ovens (rotary type, if institution is large enough), large and small mixers, refrigerators, cooling racks, proof box, steam-jacketed kettles, dough dividers and dough roller, sinks, baker's stove and garbage disposal.

This area should be located as near the cooking unit as possible. It is often in an alcove. Today, small automatic pot and pan washing machines are available. These machines have done much to improve sanitation and decrease labor turnover.

If a pot and pan washing machine is used, only one large soak sink and a garbage disposer are needed. If one of these machines is not used, a three-compartment sink must be purchased—one compartment for soaking, one for washing, and one for rinsing and sanitizing. The sanitizing is accomplished by high temperature or chemical rinse.

DISHWASHING AREA

The dishwashing area should be located adjacent to the dining area. A mechanical conveyor should be used to transport soiled dishes from the dining room to dishroom.

A conveyor-type dishwashing machine should be used as soon as the volume of dish-washing warrants it, because this type of machine eliminates prewash and racking. Rinse injectors can be used to successfully eliminate water spotting on glasses and silver.

The use of chlorinated detergents has eliminated china soaking and dipping. When using a high-powered chlorinated detergent, however, make sure the dishwasher is stainless steel inside as well as out. There can be no brass, copper or soft metal used on the inside of the machine because the detergent will literally eat up the machine. Acoustical treatment for the dishwashing area is essential.

STAFFING THE DEPARTMENT

The last, but certainly not the least, important consideration in food service programing is the staffing of the dietary department, which includes both professional and nonprofessional food service personnel. Personnel is the hospital's greatest asset. We may have the finest building and equipment but they are useless if we have no people or incompetent ones. During the war years, many hospital buildings were partially or wholly destroyed, yet the hospitals carried on through the loyalty and devotion of the personnel.

The professional and nonprofessional workers expect security, prestige and a place of dignity in the organization and community. They want to belong to a group that accepts them, respects them, and is important in its own right. A hospital can offer a worker this kind of satisfaction—the difference between "making a living" and "making life worth living".

The number of professional personnel required depends entirely on the number of patients, the kind of service given and the amount of teaching required. Obviously, a university hospital requires heavier professional staffing than a community or private hospital. Today we face the question, "Do we need professional workers in a food service?" The answer depends on whether the hospital is interested in only *quantity* and *mechanical* food service or if it is interested in *quality* food service. Quality usually costs more money and a professional person *may* cost more, but not always. The professional staff of the dietetics and nutrition department must be on a par with the other professional people in the organization. If the setting is academic, then appointments must be academic.

The nonprofessional employee in today's food service department must be well qualified. The growing use of machinery demands that personnel be skilled in the use and maintenance of this equipment. It is incongruous for a hospital to spend $10,000 to $20,000 for pieces of equipment and then hire incompetent and unskilled workers to operate and maintain the machinery. Every piece of work of one unit must be synchronized with the work in another unit. This requires that workers have intelligence as to judgment and timing.

Two common tools used in staffing are the job specification and job analysis.

The job specification should include name of the position; statement of duties; statement of hours, wages, time off, sick leave, vacation; special skills (manual dexterity, mechanical, artistic;) promotion opportunities; and personal factors (age, personal attributes, physical fitness, education, experience).

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Job analysis includes the breakdown of the job into 5-10-15-30-minute or one-hour intervals depending on when the employee changes specific duties. For example, a salad girl at 3 p.m. collects materials for salad, at 3:15 salad is mixed, at 3:30 dips salad, at 4:30 works on salad counter, and so on.

Job analysis must be re-worked at frequent intervals. The employee should be asked to assist each time that these adjustments are made. He needs to try it out to see if it is practical to follow.

Staff needs for a certain size hospital are impossible to estimate. The U.S. Public Health Service has estimated that 5 to 6 persons are needed for 25 beds to 12 to 15 for 100 beds. In staffing a dietetics and nutrition department, it must be remembered that the operation is 7 days a week, 365 days a year (holidays included), with a minimum coverage of 12 to 15 hours per day. In large hospitals, 24-hour coverage is needed to handle the midnight supper and 4 a.m. snack, and for cleaning purposes. Vacations and sick time also must be allowed for in staffing schedules.

To me, one of the most important factors in staffing and one all too often overlooked is the training program. A good training program can reduce turnover which can cost from $70 to $300 per person trained. A good training program can dissolve bottlenecks, reduce waste and spoilage, reduce accident rates, increase efficiency and production, make way for promotion, increase morale, and help supervisors to be better job instructors.

In food service programing, nothing can surpass an adequate number of qualified professional and nonprofessional personnel supplemented by an intensive training program. ■

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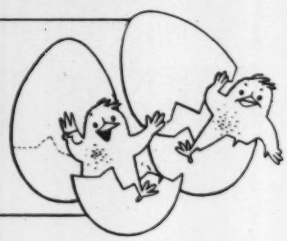
Easter Sunday Menu Inserts



SUGGESTIONS for adding festive notes to Easter menus are presented below in a separate holiday menu for the Midwest, South-Southwest, East and North-Northwest.

These holiday menus have been prepared by the authors of the AHA spring cycle menus to key in with the spring cycle menu series. Spring cycle menus were published in the January and February issues of the Journal.

On Easter, menus on p. 113 may be used in place of the menu from the AHA spring cycle menu series that would have been used on March 29.

If these substitutions are made, the appropriate weekly market order for perishables should be checked for deletion of items for the March 29 scheduled menu and substitution of items needed to produce these suggested menus.

Since one of the choices offered on the Easter Sunday menus is designed for use on modified diets, the menus can be used for both normal and modified diets.

In addition to providing a selective menu for Easter Sunday, the authors are sharing their recipes for some of the items. The recipes follow.

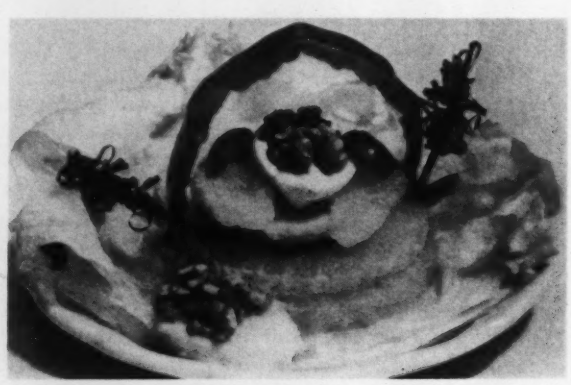
PEAR-NEST SALAD

(25 servings)

1 No. 10 can pear halves
1 lb. candy jelly beans (varicolored)
2 lbs. shredded coconut
1 tsp. green food coloring
Mayonnaise as needed

1. Toss coconut and green food

PEAR NEST SALAD



EASTER BASKET FRUIT SALAD

coloring together until the coconut is tinted.

2. On each plate, place the tinted coconut in the form of a nest.

3. Drain pears and place one pear half, cut side up, in the nest of green coconut.

4. Arrange three candy jelly beans (assorted colors) in the center of the pear and three around the pear.

5. Serve with mayonnaise.

EASTER BASKET FRUIT SALAD

(25 servings)

25 pineapple slices
5 large oranges
6 avocados
4 pink grapefruit
6 heads lettuce
1 lb. cream cheese
50 walnut halves
5 large green peppers
6 maraschino cherries
50 frilly toothpicks

1. Peel and slice oranges, reserving 25 center slices for salad.

2. Peel and section grapefruit, reserving juice. Fifty sections of grapefruit are needed.

3. Peel avocados and slice into grapefruit juice. Twenty-five slices of avocado are needed.

4. Wash and slice green peppers crosswise for handles. Twenty-five pieces of green pepper are needed.

5. Using melon scoop, shape 25 cheese balls.

6. Prepare 25 lettuce cups.

7. For each salad arrange a slice of pineapple, next a slice of orange, and then a slice of avocado. Top with two sections of grapefruit, a cream cheese ball and a walnut half. Garnish with two quarters of cherries.

8. Using two frilly toothpicks, insert toothpicks through green pepper ring and into the side of each salad to form the handle.

9. A dollop of dressing with another walnut half may be added.

HOT CROSS BUNS

(120, one and one-half oz. buns)

1 lb. sugar
1 lb. hydrogenated fat
1¼ oz. salt
¾ lb. eggs (6-7)
3½ oz. yeast
1 qt. milk
4½ lbs. flour
1¾ tbsp. cinnamon
1 tsp. mace
⅓ tsp. cloves
⅓ tsp. nutmeg
½ lb. raisins
1 c. candied fruit peel

Glaze

½ lb. sugar
½ c. white corn syrup
¼ c. boiling water

Confectioners' Frosting

2 egg whites
2 tsp. lemon juice
¾-1 c. confectioners sugar

1. Cream fat and sugar and salt together in mixing machine until well blended. Use flat paddle on second speed.

2. Add unbeaten eggs a few at a time and cream until blended.

3. Scald milk. Cool to lukewarm. Dissolve yeast in milk. (Beat with French whip.) Add to

EASTER SUNDAY SELECTIVE MENU FOR THE MIDWEST, SOUTH-SOUTHWEST, EAST AND NORTH-NORTHWEST

	breakfast	noon	night
midwest	Strawberry and Banana Fruit Cup **or** Chilled Orange Juice Oatmeal with Raisins **or** Cornflakes Scrambled Eggs—Crisp Bacon Hot Cross Buns—Assorted Jellies	Spring Fruit Punch Baked Sugar Cured Ham with Fruit Sauce **or** Breast of Chicken with Mushroom Saute (S) New Potatoes with Parsley Butter (FS) Cheesy Asparagus **or** Glazed Tiny Whole Carrots (FS) *Easter Basket Fruit Salad with Celery Seed Dressing **or** Hearts of Lettuce Wedge with Roquefort-Sour Cream Dressing Angel Fluff Dessert (FS) **or** Butterscotch Sundae with Bunny Cookie	Hot Chicken Bouillon with Caraway Buttered Toast Sticks Veal Scallopini (F) **or** Broiled Lamb Pattie with Bacon Wrap and Mint Jelly (S) Sweet Sour Waffle Cut Beets **or** Spinach a la Clarkson (FS) Olive Slaw—Sliced Tomato **or** Bing Cherry and Banana Salad in Raspberry Gelatin with Whipped Cream Dressing Pineapple Upside-down Cake with Whipped Cream **or** Broiled Grapefruit Half with Honey (S)
south-southwest	Half Grapefruit with Maraschino Cherry **or** Orange Juice Ralstons **or** Cornflakes Scrambled Egg—Grilled Sausage Links *Hot Cross Buns	Gingerale with Lime Sherbet Baked Ham with Pineapple Garnish (F) **or** Roast Leg of Lamb with Mint Jelly (S) Parsley Creamed Potato Balls (FS) Buttered Fresh Asparagus Spears (FS) **or** Creole Zucchini Squash Molded Red Apple-Date-Nut Salad on Watercress—Fruit Dressing **or** Spring Salad with Chiffonade Dressing Easter Sugar Cookies (FS) **or** Fresh Fruit in Orange Easter Baskets	Spring Vegetable Soup Sliced Turkey, Tomato and Lettuce Sandwich—Mayonnaise (F) **or** Fluffy Jelly Crested Omelet (S) Stuffed Baked Potato (S) Buttered Frozen Peas (FS) **or** Buttered Whole Kernel Corn Deviled Egg Easter Salad on Endive **or** Tinted Pear-Nest Salad—Cream Cheese Eggs *Strawberry Cream Pie (F) **or** Whole Peeled Apricots in Syrup (S)
east	Half Grapefruit **or** Pineapple Juice Farina **or** Cornflakes Scrambled Egg—Grilled Ham Hot Cross Bun	Consomme with Rice Roast Leg of Lamb—Mint Jelly (FS) **or** Roast Turkey with Giblet Gravy—Cranberry Sauce Candied Sweet Potato (FS) Buttered Asparagus Tips (FS) **or** Grilled Tomato Pear-Nest Salad—Mayonnaise **or** Chef Salad—French Dressing Strawberry Sundae **or** Bunny Sugar Cookies (S)	Cream of Mushroom Soup Minute Steak (FS) **or** Grilled Bacon and Welsh Rarebit on Toast Baked Potato (FS) Buttered Green Beans (FS) **or** Parslied Carrots *Easter Egg Salad—Mayonnaise **or** Head Lettuce Salad—French Dressing Fresh Fruit Cup **or** Springtime Gelatin Dessert
north-northwest	Apricot Nectar **or** Half Grapefruit with Maraschino Cherry Cornflakes **or** Malt Meal Cereal Colored Easter Eggs Blueberry Muffins	Fresh Fruit Cup Baked Ham (F) **or** Escalloped Turkey (S) Candied Sweet Potato (FS) Peas and Carrots (FS) **or** Baby Lima Beans Chef's Salad **or** Minted Pear Salad Strawberry Parfait **or** Rainbow Gelatin Cubes	Cream of Chicken Soup Clubhouse Sandwich (F) **or** Cheese Souffle (S) Buttered Frozen Asparagus—Hollandaise Sauce (FS) **or** Buttered Broccoli Assorted Relishes **or** Waldorf Salad Lime Sherbet **or** Rhubarb Sauce—Easter Cookie (FS)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

*Recipe and/or photograph of this item are included immediately following the menus.

Midwest Easter Sunday menu was prepared by Mrs. Helen P. Shuput, director of food service and dietetics, Bishop Clarkson Memorial Hospital, Omaha, Nebr.

South-Southwest Easter Sunday menu was prepared by Mrs. Ethelyn M. Magruder, executive dietitian, Tucson (Ariz.) Medical Center.

East Easter Sunday menu was prepared by Mrs. Elizabeth C. Downes, director, dietary department, Mountainside Hospital, Montclair, N. J.

North-Northwest Easter Sunday menu was prepared by Angeline Mannick, director of nutrition, University of Minnesota Hospitals, Minneapolis.

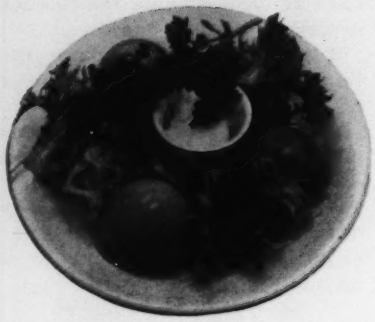
creamed sugar and fat, gradually mixing in.

4. Add fruit and spices to flour and add to above mixture. (Use dough hook on mixing machine.) Use enough flour to make smooth elastic dough. Knead. Let rise until double in bulk. Knead down.

5. Shape into round buns, 1½ oz. per bun, and place on pan approximately one inch apart. Allow to rise. When doubled in bulk, bake at 425°F. for 12-15 min. or until nicely browned.

6. When baked, brush top of each bun with glaze. To prepare glaze, mix sugar, white corn syrup and boiling water and let come to boil. Use pastry brush and brush glaze on rolls as they come from oven.

7. With metal pastry tube, make cross on each bun with the confectioners' frosting. To prepare frosting, put egg whites in bowl of small mixing machine. Beat 3 min. Continue adding confectioners' sugar until mixture is thick. Add lemon juice gradually as mixture begins to thicken. It will take 1½ to 2 cups of sugar, perhaps a little more.



EASTER EGG SALAD

EASTER EGG SALAD

(25 servings)

- **38 hard cooked eggs**
- **1 pkg. pure food Easter egg coloring**
- **4 heads chicory**
- **Mayonnaise as needed**

1. Remove shells from hard cooked eggs.
2. Color eggs (some pink, some blue, some yellow), according to the directions on the Easter egg coloring package.
3. Drain eggs on paper toweling.
4. Cut colored eggs in half, when dry.
5. Arrange three egg halves (one pink, one blue, one yellow), cut side down, on a nest of chicory.
6. Serve with mayonnaise.

STRAWBERRY CREAM PIE

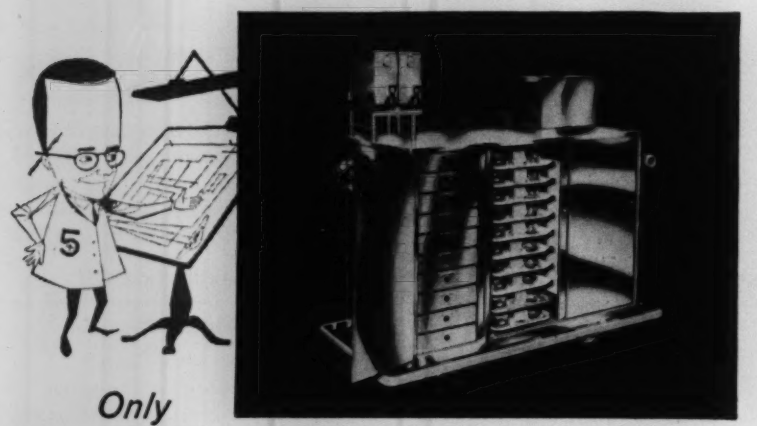
(10, nine-inch pies)

- **3 oz. plain gelatin**
- **2 c. cold water**
- **5 qts. strawberry pulp and juice**
- **4 lbs. sugar**
- **2 qts. whipping cream**
- **9 baked pie shells**

Topping

- **6 tbsp. powdered sugar**
- **1 tbsp. vanilla**
- **1 qt. whipping cream**

1. Soak gelatin in cold water.
2. Drain juice from frozen strawberries. Dissolve gelatin in boiling juice. Add sugar. Stir until dissolved. Cool.
3. When gelatin mixture has thickened to jelly-like consistency, add the crushed strawberries.
4. Whip cream until stiff and fold into strawberry gelatin mixture.
5. Fill baked pie shells and refrigerate until set.
6. Top pies with sweetened whipped cream.



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book reviews

Building leadership in nursing

also:
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EDUCATION FOR NURSING LEADERSHIP. Eleanor C. Lambertsen. Philadelphia, Lippincott, 1958. 197 pp. $5.

This volume presents a study of education for nursing practice and beginning competency for leadership. Although the study is concerned especially with the pre-service educational program in a college or university, it has meaning for all nursing personnel.

The book is divided into four major parts. The first interprets developments in nursing. The second considers the changing character of the professions and principles of professional education. The remaining sections include a definition and philosophy of nursing, concepts and principles of the professional role of the nurse and their application in nursing practice. Selected learning experiences designed to facilitate competency in the professional role are described. Excellent examples of teaching materials are included.

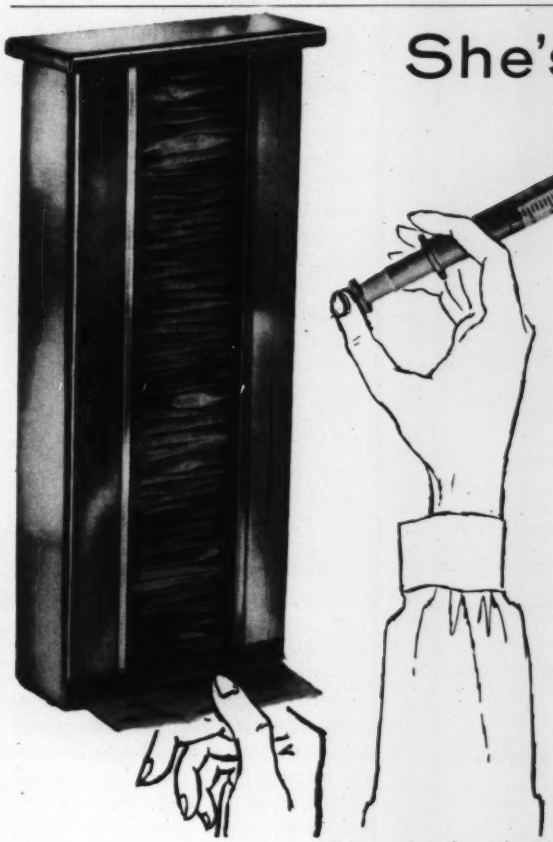
This book, an important contribution to the literature concerning the nature and meaning of nursing, explores in considerable depth fundamental characteristics of nursing, although the emphasis is placed on professional practice of nursing. The analysis of a nursing care conference is a masterful presentation of nursing needs and practice.

The book does not set out to offer a solution to the present "nursing dilemma". By shedding light on the nature of nursing, it is of interest to those practicing nursing and to employers of nursing personnel. It should be of interest to hospital administrators who want to know more about the unique contribution of the professional nurse in the hospital and in the total health situation.—ETHEL A. BROOKS, R.N., *director of the School of Nursing and Nursing Service, Hartford (Conn.) Hospital.*

Decisions, decisions

DECISION MAKING; AN ANNOTATED BIBLIOGRAPHY. Paul Wasserman. Ithaca, N.Y., Cornell University, 1958. 111 pp. $3.50.

This annotated bibliography, a by-product of a study on decision-making in hospitals carried on at Cornell University, will be of interest to many hospital administrators even though there are relatively few direct references to hospitals. At a time when the study of administrative processes



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and practices has become the concern of many disciplines, synthesis is essential if the full value of research is to be realized.

In this volume, the authors have attempted to arrange some of the pertinent literature on decision-making in a rational manner. The result is a helpful reference work of more than 400 entries classified under eight major headings. The introductory section presents materials from such diverse fields as philosophy, anthropology, operations research and management practice. Subsequent sections are devoted to values and ethical considerations, leadership, psychological factors, small groups, community forces, communication, mathematics and statistics as applied to decision-making.

Annotations are generally brief but indicate enough about the article or work to assist the reader in selection of references he may wish to pursue. The administrator who is concerned with the impact of other disciplines on his field will find this bibliography helpful as will anyone engaged in formal study, research or education in the field of hospital management. —KEITH O. TAYLOR, *associate director, Course in Hospital Administration, University of California, Berkeley.*

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Hospitals in Great Britain

The fifth in the series, *Hospitals and the State,* has recently been published by the Acton Society Trust, a British nonprofit trust established to promote economic, political and social research, and to publish material in keeping with its aims. The entire series concerns hospital organization and administration under the National Health Service.

The five parts include: (1) "Background and blueprint," a description of British hospital service before and after nationalization; (2) "The impact of the change," case studies concerning effects of national ownership on people who administer hospitals; (3) "Groups, regions and committees, Part 1," hospital management committees; (4) "Groups, regions and committees, Part 2," regional hospital boards, and (5) "The central control of the service," responsibilities and relationships of Ministry of Health, Treasury and Parliament.

These research papers may be ordered at four shillings each from the Acton Society Trust, 39 Welbeck St., London W.1, England.

Learning to be a nurse

A valuable addition to "careers" literature is found in *Student Nurse, Her Life in Pictures,* by Jack Engeman. As Lucile Petry Leone states in the foreword, "This book vividly describes the life of a student who would learn to be a nurse, and who would render services wanted and appreciated by people the world over." More than 250 informal pictures cover the entire sequence of events in the school calendar, taking the student nurse from orientation week through the various career opportunities available to graduate nurses. The book is published by Lothrop, Lee and Shepard Co., Inc., 419 Fourth Ave., New York 16, N.Y., the price is $3.50.

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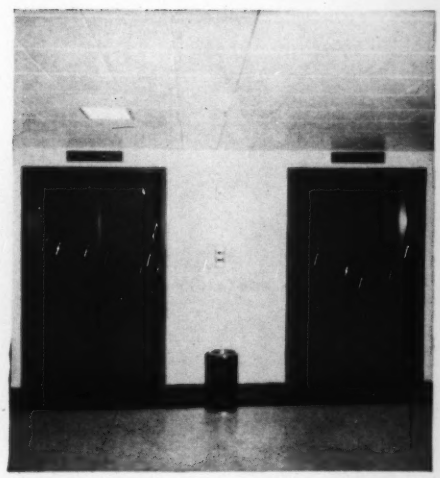

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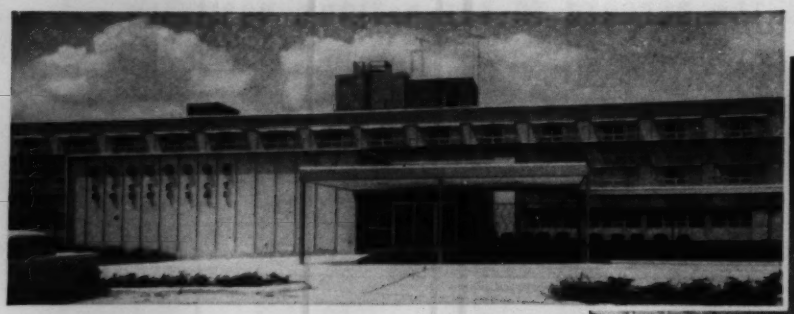

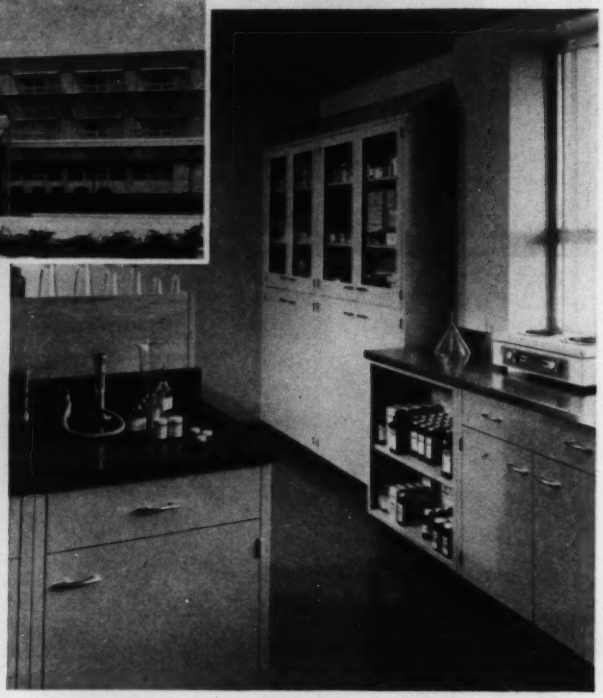

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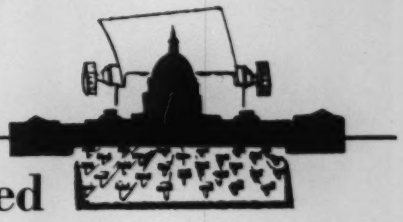

Housing Loan Program Threatened

Rep. Howard W. Smith (D-Va.), chairman of the House Rules Committee, has introduced a resolution in the House that would end the present method of financing the student nurse and intern housing loan program.

The resolution would change House rules to forbid any further loans by the federal government under the so-called public debt transaction procedures. If accepted, the resolution would require that the principal amount of all future federal loan authorizations be appropriated as part of the annual federal budget.

OBSTACLES TO HOUSING LOAN BILL—The omnibus housing bill, carrying a recommendation that $65 million be appropriated for the nurse and intern dormitory loan program, has been reported out of the House Banking and Currency Committee. AHA recommended that $150 million be appropriated for student nurse and intern housing.

The House committee's Feb. 27 recommendation is $2.5 million more than the month-old Senate-passed version; in general the House bill is more liberal than its Senate counterpart.

Differences between House and Senate versions of the bill are expected to slow its passage. Other obstacles facing the basic housing bill include: a possible presidential veto; possible action of House Rules Committee Chairman Smith. Rep. Smith killed a similar bill last year by refusing to call a meeting of his committee.

Besides the college housing program, two other sections of the bill are of direct interest to hospitals:

Proprietary Nursing Home Mortgage Loans. House and Senate both support a new program of federal guaranteed mortgages to build proprietary nursing homes. The House bill requires certification as to need by the appropriate state Hill-Burton agency. The Senate bill permits the Federal Housing Administration to bypass Hill-Burton authorities. AHA's request to include Hill-Burton construction standards was ignored in both House and Senate bills.

Housing for the Elderly. House bill provides for direct federal loans at 3.5 per cent for construction of pri-

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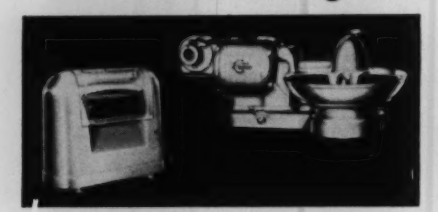

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vate nonprofit housing for the elderly. The Senate bill permits indirect loans only, with FHA acting as guarantor; Senate interest rate is 5.25 per cent.

Forand Submits New Bill

Rep. Aime J. Forand (D-R.I.) has introduced a bill which is basically similar to the proposal he made last year that the federal social security mechanism be used as the means for providing hospital-medical care for the aged. The new bill seeks to set up health care for all social security recipients. Rep. Forand has asked the House Ways and Means Committee to act promptly on his proposal.

Committee Chairman Wilbur Mills (D-Ark.) has expressed doubt that his group will have time to take up old age legislation this year.

Speaking about his new bill, Rep. Forand made reference to the interest of both the American Hospital Association and American Medical Association in the field of health care for the aged.

SEN. HUMPHREY ACCLAIMS FORAND BILL—Acknowledging his debt to Rep. Forand, Sen. Hubert Humphrey (D-Minn.) introduced a bill similar to the Rhode Island congressman's old age health bill. Sen. Humphrey's bill does not cover doctors' fees. It would provide social security beneficiaries with 120 days of hospital and nursing home care per year.

Murray-Dingle Insurance Proposal

Sen. James Murray (D-Mont.), and Rep. John Dingle (D-Mich.) have proposed that a national health insurance program be instituted. Sen. Murray said his bill was "substantially identical" to the Wagner-Murray-Dingle bill introduced 14 years ago by himself, the late New York Sen. Robert Wagner, and Rep. John Dingle, father of the present representative.

Under the new bill's provisions, it could bypass the tax-writing committees of Congress and be referred instead to the Senate Labor and Public Welfare Committee and the House Interstate and Foreign Commerce Committee, of which Sen. Murray and Rep. Dingle, respectively, are members.

Sen. Murray told the Senate: "This is a measure designed to provide a practical method through which the people of the United States will find it easily possible to meet the currently overwhelming burden of trying to pay for medical care. . . Let the record state very clearly that this bill would not socialize medicine. If enacted, the practice of medicine as we know it need not change at all. The only thing that would change would be the ability of those of our people who need medical care to get it without worrying about the cost."

Federal Employee Health Insurance

Congressional action on a federal medical program for federal employees has been postponed. Sen. Olin D. Johnston (D-S.C.) has said that Senate hearings on the issue may not get under way until late April.

Sen. Johnston says agreements on basic legislation must be worked out between insurance groups and employee groups before committee hearings. He said that in previous years, disagreement among insurance and health groups, labor, the administration, and Congress blocked the bill.

Blue Cross and Hospital Hearings

Sen. Wayne Morse's (D-Ore.) proposed investiga-

tion of District of Columbia hospital costs is now scheduled for later this month. No firm date has been set since the senator has been conducting extensive hearings on the local school lunch program.

Sen. Morse's committee staff has made it clear that the committee will not limit itself to District of Columbia hospitals. The senator also indicated his interest in financial and contractual arrangements between hospitals and medical specialists. It is known that the Morse staff has done considerable work gathering material bearing on contractual salary arrangements between hospitals and with medical specialists throughout the country.

Professional Nurse Program

Sen. Lister Hill (D-Ala.) has introduced legislation for a five-year extension of the federal award program to train graduate nurses for advanced positions. The current program expires next summer.

In proposing extension of the act, Sen. Hill has followed the recently announced recommendations of the Evaluation Conference of the Professional Nurse Traineeship Program. Since the program's beginning in the summer of 1956, some $5 million in federal funds has been given for training some 1800 graduate nurses.

In its evaluation, the conference stated that the program has "increased the number of full-time enrollments and has begun to slough off excessive and costly part-time enrollments."

Among other conference recommendations were that:

(1) The present method of administering the program be continued with future consideration to be given to the possibility of gradual "phasing out" of the prebaccalaureate programs of specialization in administration, supervision, and teaching.

(2) The feasibility of providing training grants to educational institutions be explored.

(3) Additional legislation be obtained to provide traineeships for registered nurses in programs of general nursing leading to a baccalaureate degree.

(4) If funds are available under the present law, traineeship grants should be provided for short-term institutes in administration and supervision for personnel now employed in these specialties.

The conference recommended that participating schools be encouraged to develop some programs specifically designed to train directors of hospital inservice educational nursing programs and that trainees enrolled in teaching programs be encouraged to accept inservice teaching positions in hospitals.

Senate Reviews Nursing Education

Federal aid for college training of professional nurses will be under review this spring in Sen. Hill's Committee on Labor and Public Welfare. Sen. Humphrey introduced a bill seeking such aid; it is a companion bill to one introduced in the House by Rep. Edith Greene (D-Ore.).

Rep. Greene, introducing the bill at the request of the American Nurses' Association, said "it is a surprising and sobering fact that of the 430,000 professional graduate nurses in the nation in 1956, only 30,000—some 7 per cent—have bachelors degrees from an accredited college. . . In the fields of teaching, administration, and supervision the picture is even more discouraging." She said that in these latter areas only 22.4 per cent hold bachelors degrees.

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personnel changes

● **Helen M. Bassett** has been appointed administrator of Wausau (Wis.) Memorial Hospital. She was formerly assistant director of McLaren General Hospital, Flint, Mich. Miss Bassett is a graduate of the Northwestern University course in hospital administration.

● **Wilma M. Cooper** has been appointed administrator of Fayetteville (Ark.) City Hospital. She is a graduate of the Northwestern University program in hospital administration. Mrs. Cooper succeeds **Ruth Riley, R.N.,** who has been superintendent of the hospital for 46 years.

● **Bert Erickson** has been appointed administrator of St. Peter's Hospital, Helena, Mont. **He** was formerly assistant administrator.

● **James K. Fisler** has been appointed administrator of Scott County Memorial Hospital, Scottsburg, Ind. He was formerly administrator of Nantucket (Mass.) Cottage Hospital and prior to that was with Variety Children's Hospital, Miami, Fla., in an administrative capacity. Mr. Fisler is a graduate of the Georgia State College of Business Administration program in hospital administration.

● **Edward S. Glavis Jr.** has been appointed assistant administrator of Methodist Hospital of Southern California, Arcadia. He was formerly assistant administrator of Barberton (Ohio) Citizens Hospital. Mr. Glavis is a graduate of the University of Chicago program in hospital administration.

Philip J. Hall has been appointed assistant administrator of Barberton Citizens Hospital, succeeding Mr. Glavis. Mr. Hall has been associated with the hospital for five years. He is a graduate of the University of Pittsburgh's program in hospital administration.

● **A. Madalaide DeLore Goodwin** has been appointed administrative assistant at Misericordia Hospital, Philadelphia. She was formerly administrative assistant at the Hospital Council of Philadelphia.

● **Joseph P. Greer** has been appointed director of the Children's Medical Center, Boston. He is presently administrator of the St. Luke's Division of Presbyterian-St. Luke's Hospital, Chicago. Mr. Greer is a graduate of the University of Chicago program in hospital administration.

● **Philip B. Hallen** has been appointed assistant administrator of the Boston Dispensary. He was formerly a management analyst with the Massachusetts Department of Mental Health. Mr. Hallen is a graduate of the Yale University program in hospital administration.

● **Cliff Hardin** has been appointed administrator of the Florida Sanitarium and Hospital, Orlando. He was formerly assistant administrator of the hospital.

● **Rev. Elmer L. Harvey** has been appointed administrator of Morgan County Memorial Hospital, Mar-

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tinsville, Ind. He was formerly administrative assistant at Methodist Hospital, Indianapolis. Mr. Harvey is a graduate of the Northwestern University program in hospital administration.

● **Reese E. James** has been appointed administrator of Winchester (Mass.) Hospital. He was formerly assistant director of St. Luke's Hospital, New Bedford, Mass.

● **Sam K. Johnson** has been appointed administrator of Henderson County Memorial Hospital, Athens, Tex. He was formerly with Harris Hospital, Fort Worth, Tex.

Deaths

● **William E. Barron** died Feb. 20 in Washington, Pa., at the age of 64. He had been administrator of Shadyside Hospital, Pittsburgh, for 11 years prior to his retirement in 1957. Mr. Barron had also been administrator of Washington (Pa.) Hospital from 1931 to 1942 and administrator of Citizens General Hospital, New Kensington, Pa., from 1926 to 1931. He was a fellow of the American College of Hospital Administrators and member of the American Hospital Association. Mr. Barron had served as president of the Hospital Association of Pennsylvania and as president of the Hospital Council of Western Pennsylvania.

MR. BARRON

Mr. Barron is survived by his widow, Grace; a daughter, Polly Duff; three sons, William D., Robert I., and Don M., and eight grandchildren.

● **Hubert W. Hughes** died in Denver on Feb. 24 at the age of 51. Mr. Hughes had been administrator of General Rose Memorial Hospital, Denver, from 1949 (when it opened) until 1957. He was a hospital consultant until the time of his death. Prior to his appointment at General Rose Memorial Hospital, Mr. Hughes was business manager of St. Anthony Hospital.

MR. HUGHES

During his hospital career, Mr. Hughes had been: president and trustee, Colorado Hospital Association; president, Denver Hospital Council; president, Midwest Hospital Association; Colorado's delegate to the American Hospital Association; member of AHA councils and committees; fellow of the American College of Hospital Administrators, and a director of Colorado Hospital Service (Blue Cross).

Mr. Hughes is survived by his widow, Kathryn A.; three sons, Richard H., James D., and Hubert W.; a daughter, Kathleen, and a brother, William E.

● **Rev. John G. Martin, S.T.D.,** died in Coral Gables, Fla., on Dec. 31, 1958, at the age of 73. He was a former superintendent of St. Barnabas Medical Center (known during Rev. Martin's tenure as Hospital of St. Barnabas for Women and Children), Newark, N.J. Rev. Martin is survived by his widow, Lily, his son, John D., and two grandchildren, Florence D. and Jeanne B.

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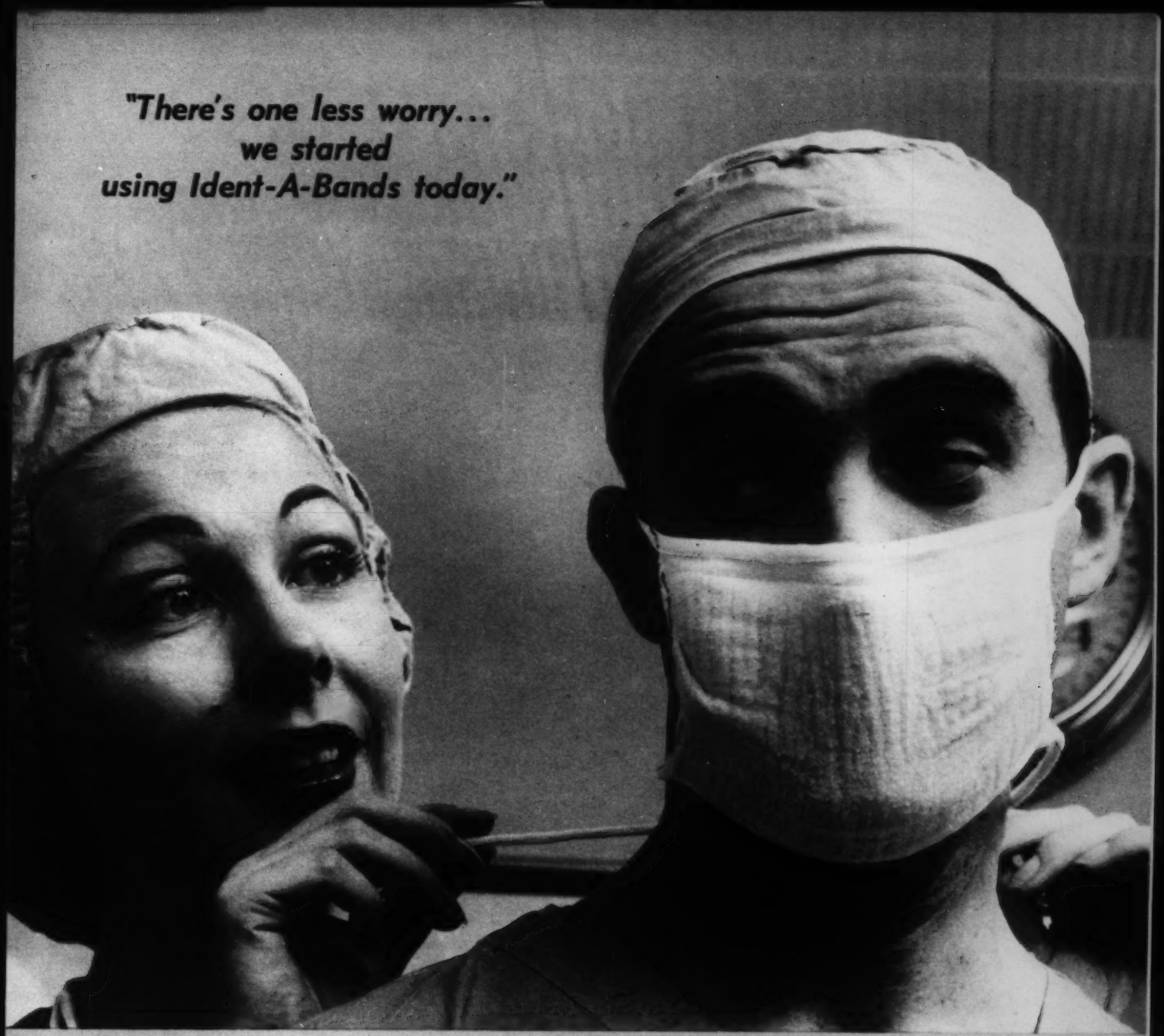

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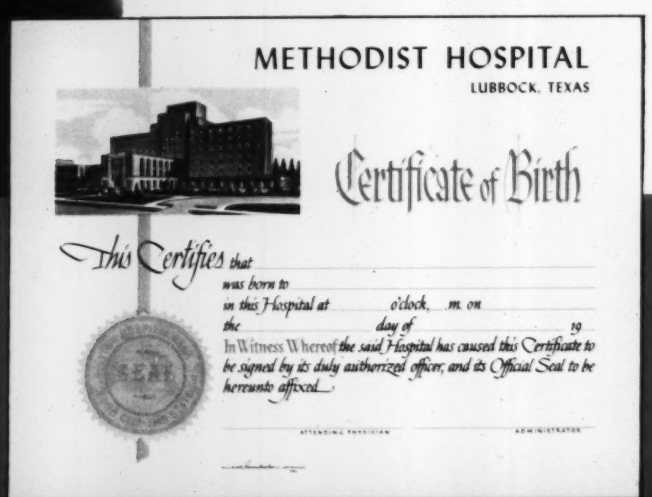
METHODIST HOSPITAL
LUBBOCK, TEXAS

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This Certifies that
was born to
in this Hospital at o'clock, m. on
the day of 19
In Witness Whereof the said Hospital has caused this Certificate to be signed by its duly authorized officer, and its Official Seal to be hereunto affixed.

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Corporate Practice of Medicine Charged

Radiologists Bring Lawsuit Against Spartanburg (S.C.) General Hospital

Radiologists at Spartanburg (S.C.) General Hospital have filed suit against the hospital to prohibit the hospital's alleged "corporate practice of medicine."

James R. Neely, executive director of the South Carolina Hospital Association, reported in the association's *Bulletin* that "H. E. Hamilton, administrator of the hospital, and each member of the hospital's board has received an order to appear in the Court of Common Pleas to 'show cause . . . why an order should not be issued enjoining and restraining the defendants (the hospital's board and administrator) . . . from interfering, or attempting to interfere, with the practice of medicine in the field of radiology, and in the use and utilization of the facilities of the Spartanburg General Hospital, especially radiological facilities, in the care and treatment of patients; as to the plaintiff making charges to his patients for his professional services as a physician; as to why any payments made to the hospital, or otherwise for the plaintiff's professional services should not be remitted and made to the plaintiff. . ."

DECLARATORY JUDGMENT SOUGHT

A complaint accompanying the order requested the judge to issue a declaratory judgment stating that:

- Radiologists are entitled to practice radiology in the hospital and to "use the facilities of the hospital as any other medical practitioner."
- Radiologists are entitled to make charges to their patients, both inside and outside the hospital, for their "professional services on a professional service basis as all other practitioners do."
- Radiologists are entitled to use the hospital's facilities "without being charged therefor."
- Patients treated in the hospital's radiology department must be charged separately for the use of the facilities.

The complaint also asked that the hospital be held accountable for and pay to the radiologists any amounts collected by the hospital since Dec. 1, 1958, "representing the professional services" rendered by the radiologists.

'UNCONSTITUTIONAL' PROVISIONS

In their complaint, the radiologists sought to have an action of the hospital's board that limits payments to radiologists to 40 per cent of the net profit from operation of the radiology department ruled "invalid, discriminatory and unconstitutional" along with a clause in the current supply bill for Spartanburg County which specifies the basis of payment to radiologists at the hospital.

(The action referred to, states: "The radiologist in charge of the department shall receive an annual salary of $10,000 for directing the work of the department and for interpreting the x-ray pictures of the charity patients. He shall receive as additional compensation 40 per cent of the net profit accruing to the department so long as his earnings in the aggregate do not exceed the sum of $25,000.")

The radiologists' complaint also sought a declaratory judgment that:

- The present operation of the hospital's radiology department is unlawful "in that it represents a corporate practice of medicine."
- The hospital's income from operation of the radiology department would be divided between a charge for the professional services of the radiologists and a charge for the use of the hospital's equipment, facilities, and personnel.
- Selection of the chief of the radiology service would be conducted in the same way other chiefs of service at the hospital are selected.

TRIAL DATE OPEN

No trial date has been set yet, but in the meantime the radiologists filed for and were granted an order requiring the hospital-radiologist relationship to remain unchanged while the litigation is pending—the hospital will continue to permit the radiologists to use the radiological equipment and the radiologists will continue to get 40 per cent of the net profit from the department's operations while the suit is in progress.

In a brief filed by County Attorney Sam T. Means in defense of the hospital, it was stated that the radiologists have no legal grounds because they are bringing suit against South Carolina, in effect, since the hospital's trustees are functioning as agents of a political subdivision. The radiologists' attorneys stated that there is legal precedent for their actions.

Mr. Means criticized the radiologists for bringing their private problem with the hospital before the public. ■

GORMAN GIVES TESTIMONY—

Mental Illness Insurance Urged

". . . Emotional illness can, and should be, covered for a minimum of 30 days a year by every health insurance plan."

This statement was made by Mike Gorman, executive director of the National Committee Against Mental Illness, in recent testimony before the New York State Joint Legislative Committee on Health Insurance Plans.

Mr. Gorman said: ". . . I want to make it crystal clear that this should be included in the basic coverage of the plan. I am against an extra rider for mental illness which asks the family to pay an extra charge for this coverage. This is actuarial nonsense. If the insurance companies of America cannot cover the most prevalent illness in the nation in their basic policies, they really forfeit the right to the patronage of the people."

Mr. Gorman presented some data on mental patients based on

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Dependability, ease of operation and economy have made Ohio-Kreiselman resuscitative units valued members of the hospital team throughout the world.

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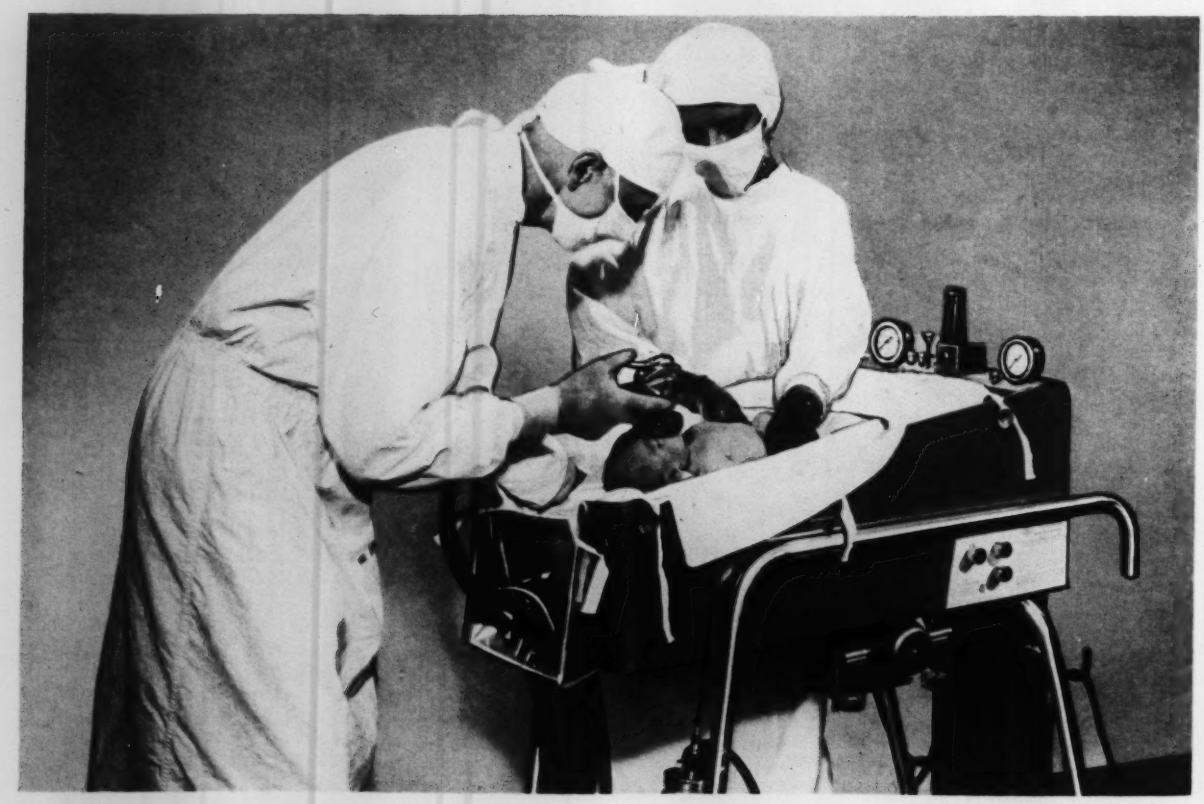
This new unit is typical of the product improvements constantly under development by Ohio Chemical research engineers.



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The latest Series No. 24 Ohio-Kreiselman Infant Bassinet Resuscitator contains all of the previous desirable features of the former models. In addition, the new-style units are completely explosion-proof. For simplicity of operation the controls and indicators for aspiration, resuscitation and inhalation are segregated. An easily adjustable sensitive thermostat controls the temperature — a thermometer indicates actual temperature in the bassinet. The unit is highly mobile, yet stable. Types are available for use with small cylinders, large cylinders, central oxygen pipeline systems — with aneroid or water manometer.

This new, explosion-proof Infant Bassinet Resuscitator provides for hyperextension of the head to place trachea in line with pharynx and mouth and to facilitate drainage. It also allows for immediate aspiration with electric vacuum pump of secretions from the air passages and stomach. Intermittent administration of oxygen under positive pressure may be applied with manual control. The unit provides for endotracheal intubation during prolonged ventilation of infants with profound asphyxia. In addition this versatile Ohio-Kreiselman Resuscitator permits free inhalation of oxygen at atmospheric pressure, minimal patient handling and maintenance of body temperature.

For descriptive literature on all Ohio-Kreiselman Resuscitators, please request Catalog 4781.
Write Dept. H-3

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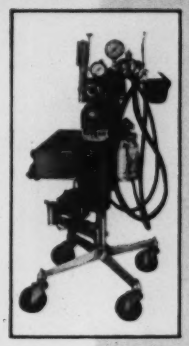

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Unit includes operative head complete with automat, flowmeter calibrated for oxygen and 80-20% helium-oxygen mixture, automatic regulator for large size cylinders, 3000-lb. cylinder pressure gauge, interchangeable inhalers, adult size catheter adapter, tubings and aneroid manometer.

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Small, efficient and portable unit. Operates on air or oxygen. Consists of 1600 cc.-capacity bellows, a face mask and valve placed between them. Safety valve limits pressure to 20 mm. Hg. All valves operate automatically.

PIPELINE RESUSCITATOR
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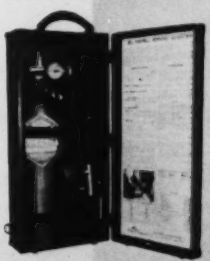

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an eight-year study by Dr. Frederick C. Redlich and Dr. August B. Hollingshead. The data were detailed in their book "Social Class and Mental Illness."

Much of the book, he said, is a study of the psychiatric facilities available to 2000 mental patients and the costs borne by the patients' families for the patients' care. The authors divided the patients into five groups by economic status—Class I the wealthiest, Class V the lowest-income group.

'CASTE DISTINCTION'

Mr. Gorman said he was shocked by the "caste distinction prevalent in public psychiatric clinics." Excluding Class I patients, who rarely use a public clinic, Mr. Gorman said that the "survey documents the fact that Class II patients receive the most therapy and Class V patients the least, leading Drs. Redlich and Hollingshead to conclude that 'the subtleties of status enter into the practice of psychiatry in clinics as well as in private hospitals and in private practice.'"

He said that "Class V patients rarely use any general or private psychiatric facilities. In the other four classes the length of hospital stay is directly related to the pocketbook. For example, the average length of stay for the Class I group is 138 days as against 27 days for the low-income Group IV patients. . .

Mr. Gorman reported that a study by the Health Insurance Plan of Greater New York of its subscribers showed that only approximately 10 per cent of the group were "in a financial position to buy even minimal private psychiatric care."

ONE PLAN'S EXPERIENCE

Referring to the experience of Blue Cross of Northeast Ohio (Cleveland) in providing mental illness hospitalization benefits, Mr. Gorman said the Plan has had mental illness provisions for 20 years and "the cost of such care has been running somewhat less than one per cent of total hospital claims of all types. . .

"While the Cleveland Blue Cross Plan provides 120 days of hospital care for mental illness, the average length of stay of psychiatric patients is only about 30 days. Furthermore, insurance actuaries argue that as you increase the insurance coverage of mental illness, you will prolong the hospital stay of psychiatric patients. The Cleveland experience is exactly the reverse of this. Although the days of coverage were extended from 21 to 120 days between 1945 and 1953, the average length of stay of the psychiatric patient decreased from 37 days in 1947 to 29 days in 1956. This latter figure is undoubtedly due in great part to improved treatment procedures now available to psychiatric patients. ■

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Dr. Bates Named Director Of Hospital in Baltimore

Dr. LeRoy E. Bates, assistant director of the American Hospital Association, director of the Department of Professional Services and secretary of the Association's Council on Professional Practice, has accepted an appointment as director of 361-bed Union Memorial Hospital, Baltimore.

DR. BATES

Dr. Madison B. Brown, associate

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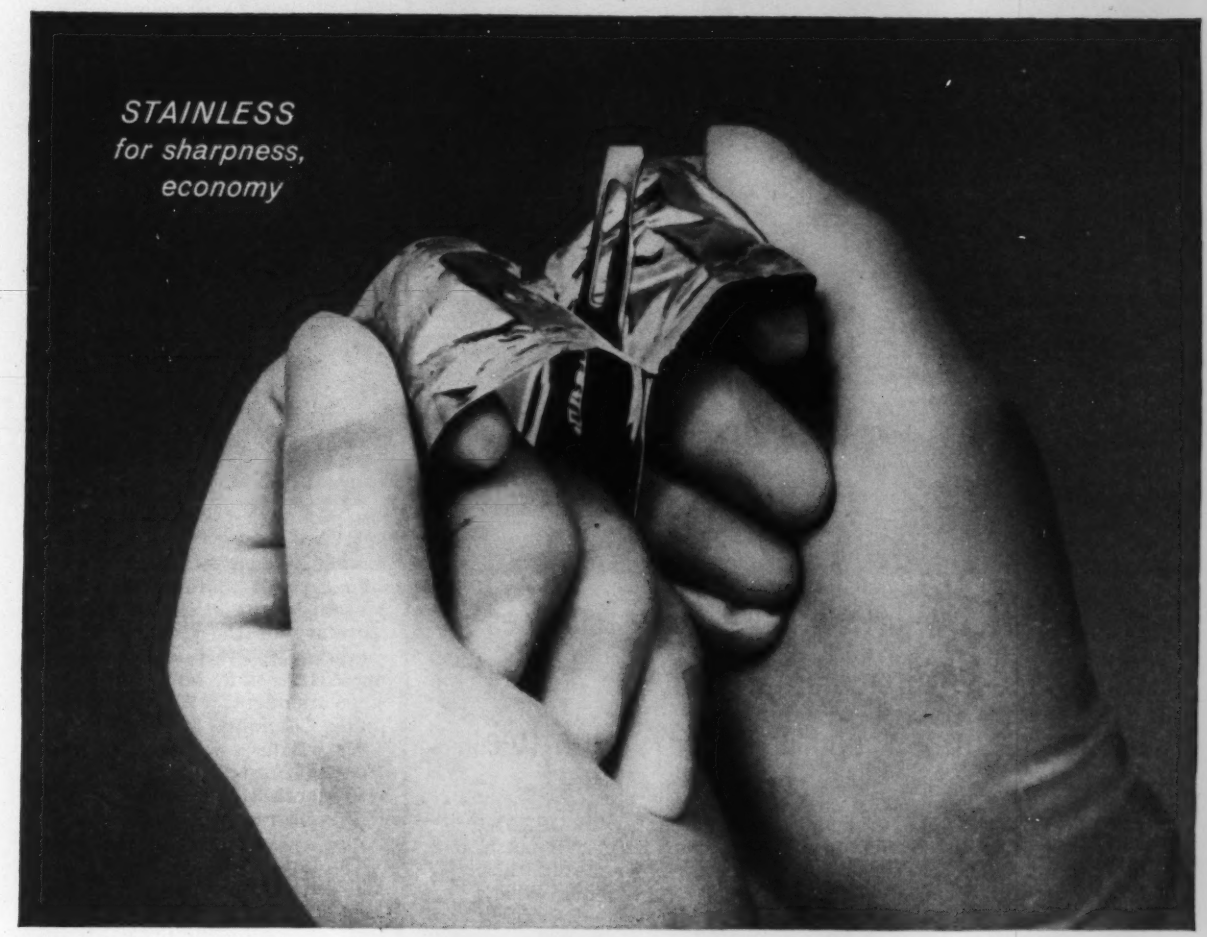

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Your cleaning personnel will welcome the way COMET quickly and easily removes stubborn stains and disinfects to leave surfaces looking "Surgery-clean"! Ask your supplier for special prices on COMET by the case.

BEFORE! Micro-photograph shows typical bacteria found on bathroom sinks.

AFTER! Lab tests show conclusively COMET disinfects as it cleans!

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director of AHA, becomes director of the Department of Professional Services and secretary of the Council on Professional Practice, Dr. Edwin L. Crosby, director of the Association, has announced. Before joining the Association's staff, Dr. Brown was executive director of Hahnemann Medical College and Hospital, Philadelphia.

DR. BROWN

MR. JOHNSON

In another Association appointment, Dr. Crosby announced that Richard L. Johnson has been named assistant director of the Association, with responsibility for the Department of Administrative Services, previously headed by Dr. Brown. Mr. Johnson will continue to hold his present Association position as secretary of the Council on Administrative Practice. Before joining AHA's staff, Mr. Johnson was superintendent of University Hospitals, Columbia, Mo.

Dr. Bates, whose resignation from the Association staff is effective March 31, succeeds Carroll D. Hill, who recently resigned as director of Union Memorial Hospital.

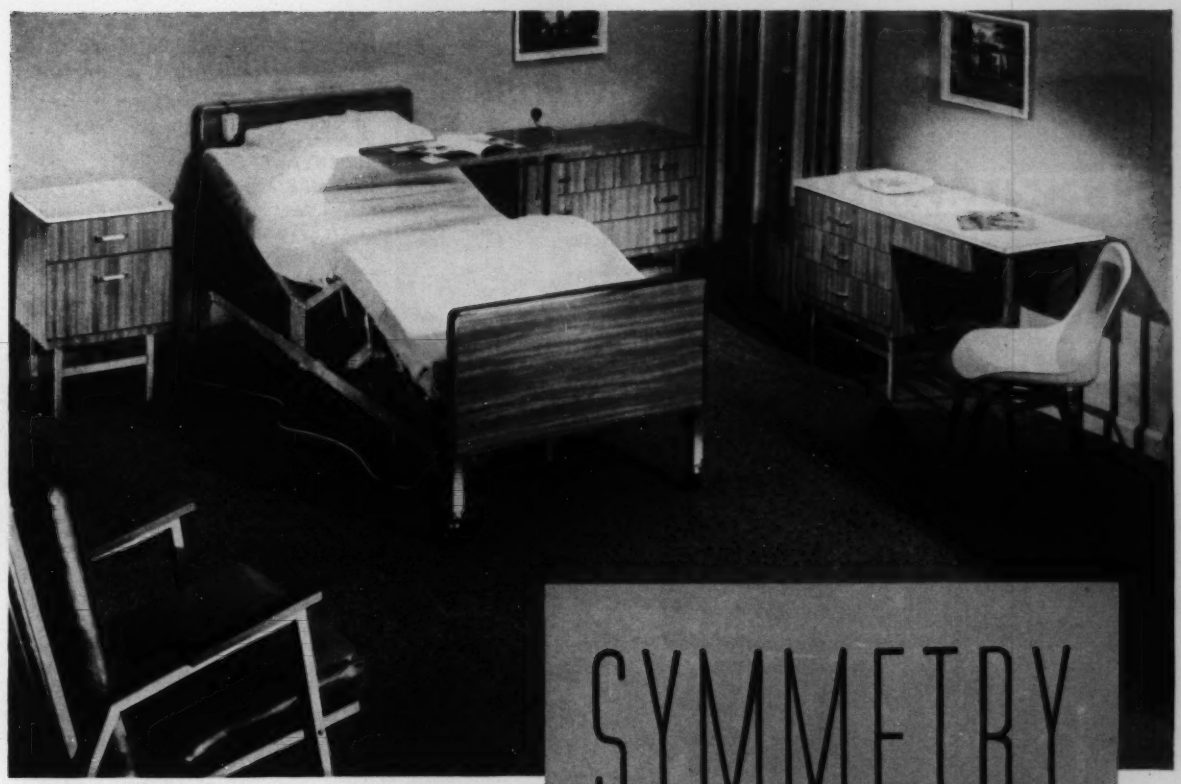
Dr. Bates, 36, received his medical degree from the Medical College of South Carolina and a master's degree in public health from the University of California.

Immediately prior to his joining the AHA staff, Dr. Bates was assistant director in charge of outpatient services at Johns Hopkins Hospital, Baltimore.

In June 1955, Dr. Bates was named assistant secretary of the Council on Professional Practice and a year later was named associate secretary of the council. In July 1957, he was named secretary of the council and in December 1957 became assistant director of the Association, in addition to his council post. ■

Dr. Frechette Takes Post As State Health Commissioner

Dr. Alfred L. Frechette has been appointed commissioner of public health for Massachusetts. He was



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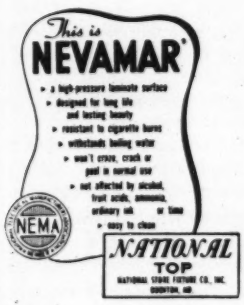

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formerly director of the Health, Hospitals, and Medical Care Division of the United Community Services of Metropolitan Boston and director of the Hospital Council of Metropolitan Boston, which is part of the Medical Care Division.

DR. FRECHETTE

Edward B. Kovar, formerly of the American Public Health Association, has been appointed director of the Medical Care Division. William F. Voboril, secretary of the council, said a new director for the council is not expected to be named.

Correspondence to the council should be addressed to Mr. Voboril at 14 Somerset Street, Boston 8.

Dr. Frechette received his medical degree from the University of Vermont in 1934 and received a master's degree in public health from the Harvard School of Public Health.

From 1942 to 1945, Dr. Frechette was state health commissioner for New Hampshire. From 1945 to 1950 he was director of public health for Brookline, Mass. In 1950 he joined the staff of United Community Services of Metropolitan Boston.

Since 1949 Dr. Frechette has been assistant professor of public health practice at Harvard University, a position he still holds.

Dr. Frechette has served on committees of the American Hospital Association, Massachusetts Hospital Advisory Council, and American Public Health Association. He is also state surgeon of the Massachusetts National Guard. ■

10 Hospital Housekeepers Given $350 Scholarships

The 10 winners of $350 scholarships which had been made available by Huntington (Ind.) Laboratories to those attending the 11th annual Short Course in Hospital Housekeeping have been announced.

Winners were selected on the basis of their 500-word papers on the subject: "What Benefits I Expect to Obtain from the Short Course in Hospital Housekeeping."

Scholarship winners are:

Arnold Aspin, housekeeper, Hamilton (Ontario) General Hospital.

Grace A. Champigny, executive

a plan of attack

against the spread of infections in hospitals

THE WAR IS ON! Never, since the days of Lister have hospital personnel been waging such a fierce war.

Then the enemy was all types of germs.

Today it is *staphylococcus aureus* 52/42B/81 and other uncontrolled resistant strains. These organisms are producing serious infection in patients, newborn infants and hospital staff.

INFECTIVE AGENT AIR-BORNE. It has been rather clearly established that the infective agent is usually air-borne in the form of dried fomites after originating in a septic wound. The primary means of distribution is the respiratory tract of hospital personnel. The pathogens settle everywhere. Tests have shown them to be hardy with survival from a few days to many months.

There is only one apparent effective control: *complete disinfection throughout the hospital.*

It must be continual—there must be a return to the "old fashioned" hospital attitude and methods of asepsis. No longer can we let antibiotics substitute for the tried and true methods of cleanliness.

PLAN OF ATTACK AVAILABLE. Huntington Laboratories has developed a brochure which presents an outline for over-all control of infections in hospitals. To be successful, it must be instigated by the Administrative Head of the hospital. Copies of "A Suggested Plan for Infection Control in Hospitals" are available without charge. Send for it. We think you will find it helpful.

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George Imandt, executive housekeeper, Herbert J. Thomas Memorial Hospital, South Charleston, W. Va.

Janet G. Brodahl, executive housekeeper, Bethesda Lutheran Hospital, St. Paul.

Oneita Mendenhall, executive housekeeper, Rowan Memorial Hospital, Salisbury, N. C.

Dora L. Rarrick, assistant housekeeper, Arnot-Ogden Memorial Hospital, Elmira, N.Y.

John J. Schober, supervisor, housekeeping and laundry services, Winnebago (Wis.) State Hospital.

Emma Louise Schroeder, executive housekeeper, St. Vincent Charity Hospital, Cleveland.

Carrie Elizabeth Ward, chief housekeeper, Lakin (W. Va.) State Hospital. ■

Columbia Offers Mail Course To Hospital Administrators

Columbia University is again inviting administrators of hospitals of 100 beds or less to enroll in its correspondence-type course in hospital administration. This is the third year that the course has been offered.

Admission to the course, "basic hospital administration," is open to administrators regardless of educational background, except for those who have had prior academic work in hospital administration.

Columbia's course is given in three parts:

- Part one—an intensive two-week program at the school in New York City, scheduled from June 1 to June 12.
- Part two—the "home-study" portion of the program extends from June 1959 to June 1960 and consists of 11 monthly lessons to be done by the participant at home. The lessons include extensive reading in specially prepared texts and written assignments which are reviewed with the student by a preceptor appointed by the university.
- Part three—a second two-week period of study on the university's campus. This session is to take place in June 1960.

Tuition for the entire course is $200, which does not include housing or board in New York City, the university stated. No academic credit is granted by the university for this course.

Faculty for the course is drawn from the School of Public Health and Administrative Medicine and from agencies in the health field in the New York City area. ■

Asian Influenza Outbreak Possible, Dr. Burney Warns

The World Health Organization has alerted the United States to increasing reports of outbreaks of various types of influenza in several European countries, Surgeon General Leroy E. Burney reported.

The British press stated that early in February hospitals had been swamped with patients ill with influenza. An epidemic of Type A influenza was reported to have affected a large number of persons in Soviet Russia. Type B infections have been identified in Italy and the Netherlands.

Although no outbreaks of influenza in the United States have been reported so far, further introduction of the disease into this country is probable, Dr. Burney stated. He asked health officers to promptly report any laboratory confirmations.

Dr. Burney repeated his previous recommendation that pri-

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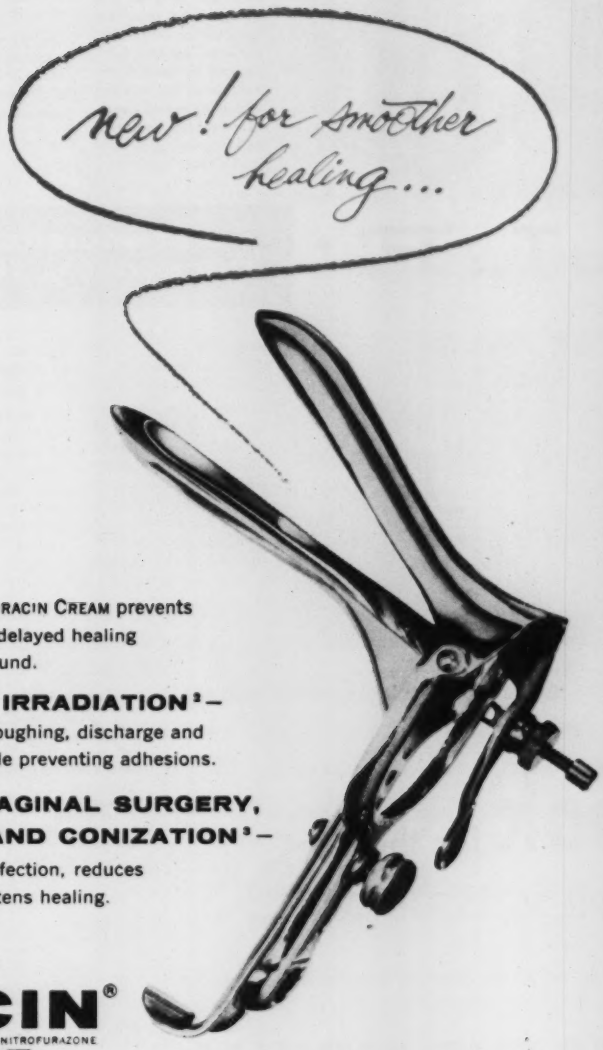

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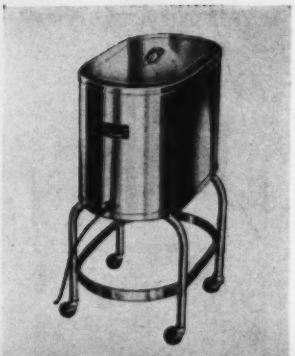

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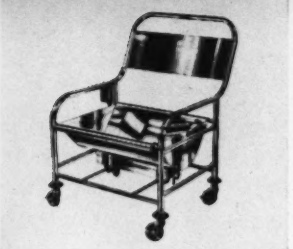

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Hospital Training Directors To Meet May 4-7 in Detroit

The American Society of Training Directors has scheduled its annual conference for May 4-7 in Detroit.

For the second year, hospital training directors, inservice education directors, personnel directors, supervisors and department heads involved in on-the-job preparation of hospital personnel, will meet as a special interest group during the annual conference.

Further information about the conference may be obtained from Fred Linsell, P. O. Box 825, Detroit 31. Further information about the hospital group session may be obtained from Mary Annice Miller, inservice education consultant, Department of Hospital Nursing, National League for Nursing, 2 Park Avenue, New York City 16. ■

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BAUMGARTNER, JOHN T.—student in hosp. adm.—Michigan State University—East Lansing.

BOARDMAN, ROBERT C.—adm. asst.—Newton-Wellesley Hospital—Newton Lower Falls, Mass.

BOGGAN, W. BRUCE, SR.—adm.—Forsyth County Hospital—Cumming, Ga.

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ASSOCIATION SECTION

(Continued from page 72)

and others in varying degrees emanate from sources away from the hospital environment arranged by delegation to others who may be unfamiliar with hospital safeguards and policies.

5. *The organization of pharmaceutical services should include the utilization of an organized Pharmacy and Therapeutics Committee responsible for the development of rules and regulations pertaining to professional policies related to pharmaceutical services for hospital patients.*

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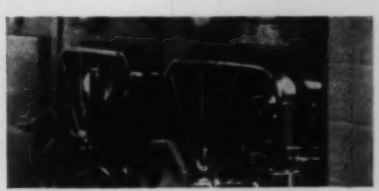

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capacity are the most qualified to recommend to the hospital such policies as relate to selection, evaluation and distribution of drugs used in the hospital. The composition and specific objectives of the Pharmacy and Therapeutics Committee as well as its appointment may be developed to best meet the needs of the hospital and its standards.

Functions

1. *The primary functions of the service provided by a part-time pharmacist should be to furnish drugs with sufficient dispatch so that patient care will not be hindered, to provide adequate safeguards for the patient and hospital personnel, and to provide therapeutic agents of respected quality.*

Responsibilities do not begin or end with filling prescriptions or furnishing drugs remotely from the hospital. The well-rounded and minimum responsibility might include such personal services by the part-time pharmacist as staff education related to safeguards in use of drugs on the premises, contribution to educational or research programs where extant, provision of maximum consultation services to nursing and medical staffs, inspection of drug storage and distribution throughout the hospital, attendance at committee and department meetings, preparation of fiscal and professional reports where necessary, maintenance of an approved stock of emergency drugs, provision for 24-hour drug services, elimination of waste, etc.

2. *Records concerned with hospital patient services should be maintained separately, preserved for the period prescribed by legal or hospital requirements, and be readily available.*

Such records as narcotic, barbiturate, alcohol, prescription, and requisition requests differ between hospitals and retail pharmacy practice. Identification with a hospital transaction or treatment may be of prime importance.

3. *The relationship between the hospital and the part-time pharmacist in the function of drug procurement or purchasing for both patient and general hospital use should be based on fixed responsibilities and meet the following principles on business relationships.*

The smaller hospital generally purchases supplies through a modified central channel in the organization. The need for expert evaluation of specifications in the drug field is recognized. Hospitals contributing services to indigent patients enjoy special price privileges, and drugs in this category ethically should not be diverted to other outlets. The complexity in the area of procurement and possibility of abuses by either the hospital or the part-time pharmacist require careful evaluation of the procedure.

a. *That basis of financial arrangement between a hospital and part-time local pharmacist should be followed which would best meet the local situation without exploitation of patient, pharmacist or hospital. It is recognized that no one basis would be applicable or suitable in all instances.*

The hospital and the part-time

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pharmacist must have a thorough appreciation of each other's business systems and controls. This may involve detailed exploration.

b. *Arrangements involving services to patients through voluntary insurance, indigent patients, or employees should be established in accordance with accepted hospital relationships and philosophies involving such programs.*

Some insurance plans vary between localities, and in some instances the so-called "no-pay or part-pay" patients comprise a sizable number of persons. Special financial arrangements in accord with hospital policy for other services provided may be required.

c. *Arrangements for a regular schedule for the personal services of the part-time pharmacist on the hospital premises should be made on a flexible basis related to time spent and services provided.*

The hospital schedule and its 24-hour service to patients demands a varying amount or period spent during regular visits or to meet emergency requirements. In general, an average amount of time may be considered initially. Such an arrangement should be included in a plan, even though many services are provided remotely from the hospital premises.

d. *Solicitation of patients or rendering services to the medical staff for their private practice through hospital channels by any person connected with the hospital is unethical.*

The privilege of hospital affiliation should not be used to gain unfair advantage over other members of the profession. Patients and physicians are attracted to a particular pharmacy because of its known merit and established reputation for satisfactory service. Implied or open solicitation through hospital connections should not be indulged in by part-time pharmacists.

e. *Relationships between a part-time pharmacist and the hospital are considered on the merit of reputable, prompt service to patients at reasonable cost, ability to serve the hospital in all phases of pharmacy service demanded by hospital requirements, and should subscribe to the suggested principles.*

In communities where several pharmacies are available, a hospital may hesitate to engage the services of any one pharmacist because of pressures and ill-feeling against the hospital by other pharmacists. Intra-professional rivalry should not place the hospital in a position of not raising its own pharmacy service standards. The hospital as a community institution should be allowed the privilege of judging its future relationships for expanded services on the basis of a part-time pharmacist's ability to provide those services in the spirit in which patient care is provided in that hospital.

Conclusion

These Principles of Relationship Between Smaller Hospitals and Part-time Pharmacists for hospitals are suggested. These recommended guides for further development and discussion are a beginning for those hospitals and pharmacists who wish to explore

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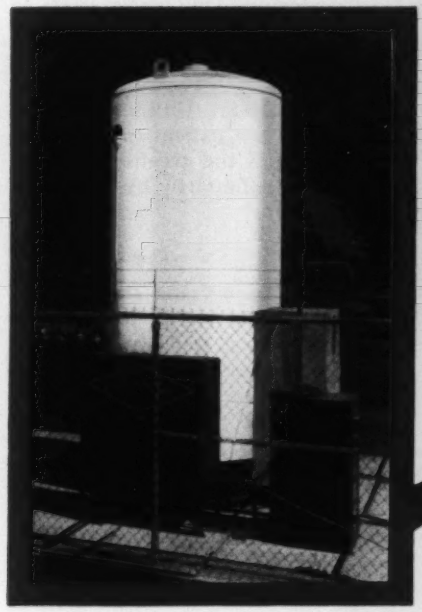

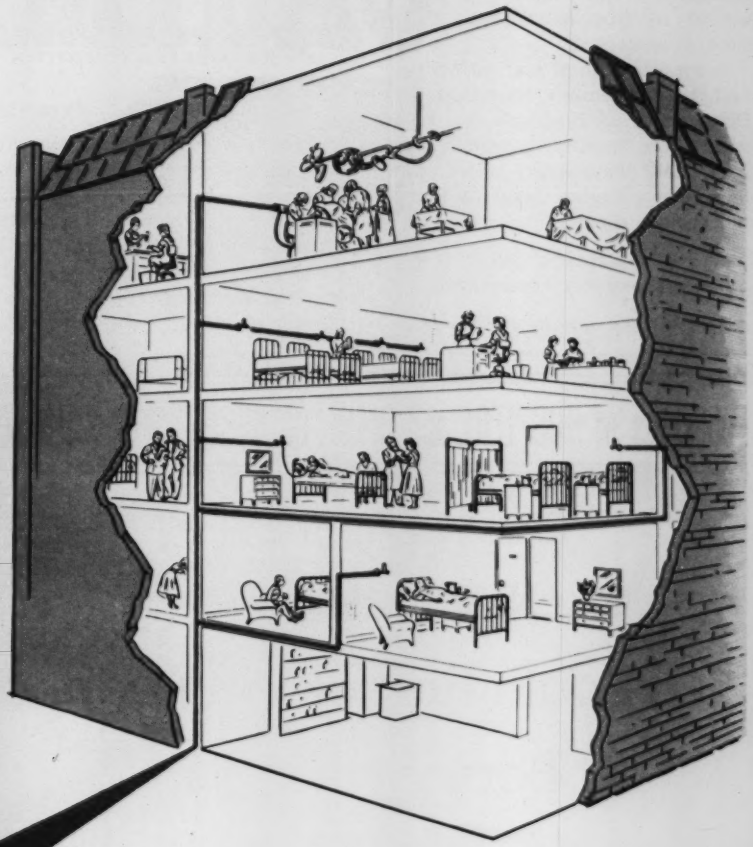

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possibilities for developing higher standards of pharmaceutical service in institutions without full-time pharmacists.

A combination of such principles and the Minimum Standard for Pharmacies in Hospitals can provide both smaller hospitals and part-time pharmacists a working basis for a higher level of pharmaceutical service.

PHARMACY AND
THERAPEUTICS COMMITTEE

VOTED: To approve the Statement on the Pharmacy and Therapeutics Committee.

STATEMENT ON THE PHARMACY AND THERAPEUTICS COMMITTEE

Preamble

Hospitals organize and marshal the best professional skills and judgment available to provide care and treatment of patients. The treatment of these patients in many cases is dependent upon the effective use of drugs. The multiplicity of drugs available today makes it mandatory that an organized, sound program of activity be developed within the hospital to insure that patients receive the best care and protection possible.

One of the most effective ways of providing this kind of care and protection is by organizing a Pharmacy and Therapeutics Committee. This committee is designed to make maximum use of available professional skills and judgment. The establishment of a Pharmacy and Therapeutics Committee is strongly recommended to all hospitals. It is a measure which supports and enhances the principle of self-government in the area of high drug standards and practices for the medical staff connected with a hospital. Ultimate benefits accrue to the patient in improved patient care and treatment as established voluntarily by the medical staff.

The Committee

The Pharmacy and Therapeutics Committee is an advisory group of the medical staff and serves as the organizational line of communication or liaison between the medical staff and the pharmacy department. This committee is composed primarily of physicians and the pharmacist and is selected under the guidance of the medical staff. It is also a policy-recommending body to the medical staff and to the administration of the hospital on all matters related to the use of drugs. (This committee does not have intrinsic authority or power of action unless specifically granted such authority.)

Purposes

The primary purposes of the Pharmacy and Therapeutics Committee are:

A. Advisory. The committee recommends the adoption or assists in the formulation of broad professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to drugs in hospitals.

B. Educational. The committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff (doctors, nurses and

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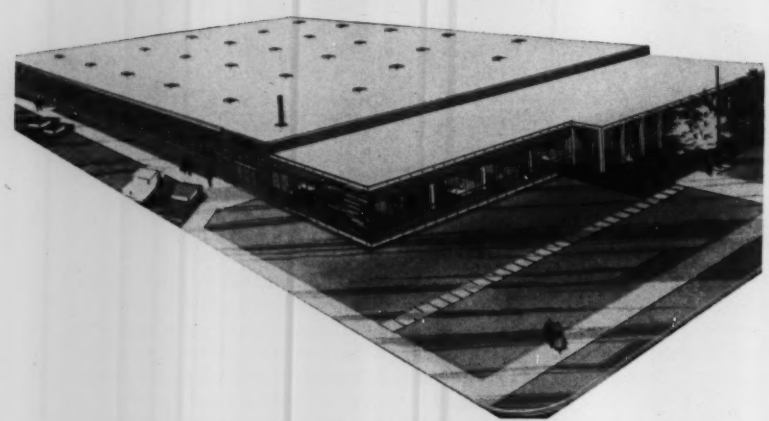

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FORMULA

the pharmacist) for complete current knowledge on matters related to drugs and drug practices.

Organization

While the composition of the Pharmacy and Therapeutics Committee may vary from hospital to hospital, the following is offered as a guide:

A. The Pharmacy and Therapeutics Committee of the medical staff should be composed of no less than three physicians and the pharmacist, appointed by a governing unit or elected official of the organized medical staff. The hospital administrator or his designated representative should be an *ex officio* member of the committee.

B. A chairman from the physician representatives should be appointed. The pharmacist is generally designated secretary.

C. The Pharmacy and Therapeutics Committee should meet regularly, no less frequently than twice per year, and should meet on call when necessary.

D. The committee should feel free to invite to its meetings persons within or without the hospital who can contribute from their specialized knowledge or experience.

E. An agenda is desirable and should be prepared and submitted to members of the committee in sufficient time before the meeting.

F. Minutes should be kept by the secretary and should be maintained in the permanent records of the hospital.

G. Recommendations of the Pharmacy and Therapeutics Committee shall be presented to the medical staff or its appropriate committee for adoption or recommendation.

Functions and Scope

The basic organization of the hospital and medical staffs will determine the functions and scope of the Pharmacy and Therapeutics Committee. The following list, which is not necessarily comprehensive, is offered as a guide:

A. To serve in an advisory capacity to the medical staff and hospital administration in all matters pertaining to the use of drugs.

B. To serve in an advisory capacity to the medical staff and the pharmacist in the selection or choice of drugs which meet the most effective therapeutic quality standards.

C. To evaluate objectively clinical data regarding new drugs or agents proposed for use in the hospital.

D. To prevent unnecessary duplication of the same basic drug or its combinations.

E. To recommend additions and deletions from the list of drugs accepted for use in the hospital.

F. To develop a basic drug list or formulary of accepted drugs for use in the hospital and to provide for its constant revision.

G. To make recommendations concerning drugs to be stocked in hospital patient units or services.

H. To establish or plan suitable educational programs for the professional staff on pertinent matters related to drugs and their use.

I. To recommend policies regarding the safe use of drugs in hospitals, including a study of such matters as investigational drugs,

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Bed capacity increased only 12%

KETCHUM, INC. *can help you raise funds for needed expansion*

Ketchum, Inc. has over 40 years' experience in helping hospitals raise funds for expansion. We have directed hundreds of successful fund-raising campaigns for both large and small hospitals.

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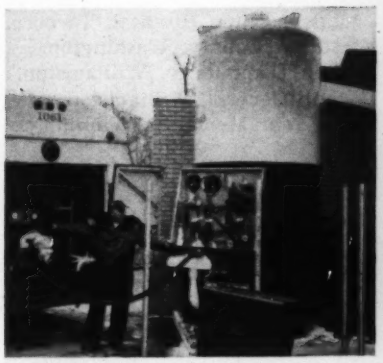
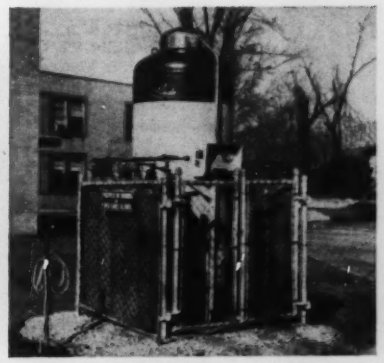
Learn how you can take advantage of more than 50 years of LINDE experience in the oxygen business. Call your nearest LINDE representative or distributor. Or write Linde Company, Division of Union Carbide Corporation, 30 East 42nd St., New York 17, N. Y. In Canada: Linde Company, Division of Union Carbide Canada Limited, Toronto.



Surprisingly compact, this 90 VCC unit holds 90,000 cu. ft. of oxygen. It's a relatively small package because at atmospheric pressure liquid oxygen in its gaseous state would require 862 times more storage space.



One of the most popular storage units is LINDE's new AT-25. It holds 25,000 cu. ft. of oxygen, yet fits in an area only five feet square.

Both portable and compact, the LC-3 container can be moved about by one man—yet holds 3000 cu. ft. of oxygen, the same as 12 conventional cylinders. LC-3's can be used at the bedside or manifolded to provide a continuous supply to the piping system.

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hazardous drugs, and others.

J. To study problems involved in proper distribution and labeling of medications for inpatients and outpatients.

K. To study problems related to the administration of medications.

L. To review reported adverse reactions to drugs administered.

M. To evaluate periodically medical records in terms of drug therapy.

HOSPITAL LISTINGS

VOTED: To approve the recommendations of the Committee on Listings.

Following are the hospitals which had been recommended for listing by the Committee on Listings.

CALIFORNIA

Stanford Convalescent Home, Palo Alto.

COLORADO

Estes Park, Estes Park.

FLORIDA

Lakeside, DeFuniak Springs.
Hollywood, Hollywood.
Kissimmee, Kissimmee.
Bel-Aire General, Miami.
Palmetto Medical Clinic-Hospital, Wauchula.

ILLINOIS

Ida Mae Scott, Chicago.
Orthodox Jewish Home for the Aged, Chicago.
Park View Home, Chicago.
Rehabilitation Institute of Chicago, Chicago.
St. Vincent's Infant, Chicago.

INDIANA

Memorial, Columbia City.
Whitley County Memorial, Columbia City.
Air Force, Bunker Hill Air Force Base, Peru.

LOUISIANA

L'Herrisson Clinic and Hospital, Coushatta.
Gonzales, Gonzales.
Metairie, New Orleans.

MICHIGAN

Glen Eden, Warren.

MINNESOTA

Ada, Ada.

MISSOURI

Air Force, Grandview.

NEW YORK

St. Mary's Hospital for Children, Bayside.
Keene Valley, Keene Valley.
Burke Foundation, White Plains.

NORTH CAROLINA

Columbia, Columbia.
Chowan, Edenton.
Good Hope, Erwin.
Henderson-Crumpler Clinic Hospital, Mount Olive.
Brewer-Starling Clinic Hospital, Roseboro.
Quigless Clinic Hospital, Tarboro.
Beauford County, Washington.
Brown Community, Williamston.
Martin General, Williamston.
Cape Fear Memorial, Wilmington.

OHIO

St. Francis, Cambridge.
Lodi Community, Lodi.
People's, Mansfield.
Shadyside, North Canton.

OKLAHOMA

Tillman County Memorial, Frederick.

OREGON

Air Force, Portland International Airport, Portland.

PENNSYLVANIA

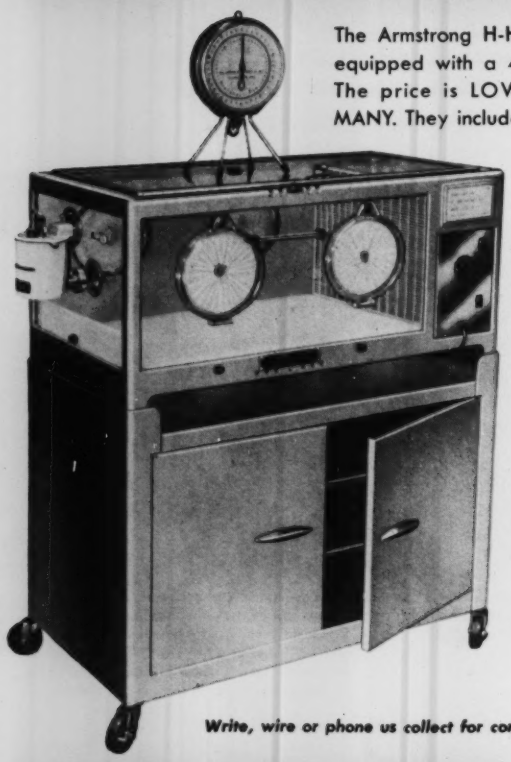
Eugenia Memorial, Chestnut Hill.
Philadelphia Freemasons Memorial, Elizabethtown.

TEXAS

Bowie Clinic Hospital, Bowie.
Childress General, Childress.
Adair, Clarendon.
Rogers, Decatur.
Clay County Memorial, Henrietta.
Rockwall Medical Clinic Hospital, Rockwall.

Armstrong H-H

Hand-hole type Baby Incubator



The Armstrong H-H is a LARGE incubator equipped with a 40% oxygen nebulizer. The price is LOW—the FEATURES are MANY. They include:

- 4-compartment mobile cabinet
- 40% oxygen limiting valve
- 3-stage humidity reservoir
- slide-opening for tube-feeding
- emergency opening top-lid—safety glass
- clear plexiglas ends and sides
- foam mattress with plastic cover
- 2 pre-shrunk weighing hammocks
- large enough for a 25-inch baby

Write, wire or phone us collect for complete details

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RISING O.R. COSTS...
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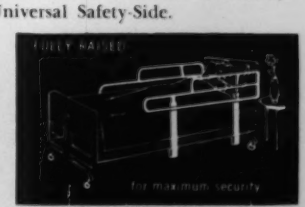
DUAL PURPOSE UNIVERSAL SAFETY SIDE BY Royal®

- Permits ambulent patients to get in or out of bed unaided
- Provides full protection against roll-out

A real time-saver for your busy staff! *Royal* DOUBLE-DUTY Safety Sides provide complete, nonconfining protection against bed-falls, yet permit ambulent patients the freedom and convenience of getting in or out of bed at will. *Also Available;* New short-length (41½") Universal Safety-Side.

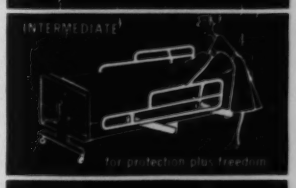
NEW SIMPLICITY

With Safety Side in intermediate position (shown above), foot end is lower than surface of mattress. Patient can easily swing feet to floor. Top bar and bed end provide hand-support for reassuring assistance. Side at center and head of bed remains sufficiently high to prevent accidental roll-outs.



FINGER-TIP ADJUSTMENT

Chrome-plated sides adjust in seconds to up, intermediate, or down position. And, these new DOUBLE-DUTY sides may be used *interchangeably* on the same brackets as standard *Royal* Universal Safety Sides.



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New, practically tamper-proof button release inset in bevelled guard locks sides in intermediate or full-up position. Locking plunger is double-size for maximum safety.

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ALASKA

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Air Force, Ladd Air Force Base, Fairbanks.

Griffin Memorial, Kodiak.

REAPPROVAL OF PLANS

***VOTED:** To reapprove the following 83 nonprofit hospital service plans as complying with the Approval Standards of the American Hospital Association, and to commend them for meeting this test of service in the areas in which they operate:*

Blue Cross-Blue Shield of Alabama, Birmingham.

Associated Hospital Service of Arizona, Phoenix.

Arkansas Medical and Hospital Service, Inc., Little Rock.

Hospital Service of Southern California, Los Angeles.

Hospital Service of California, Oakland.

Colorado Hospital Service, Denver.

Group Hospital Service, Inc., Wilmington, Del.

Group Hospitalization, Inc., Washington, D.C.

Blue Cross of Florida, Inc., Jacksonville.

United Hospitals Service Association of Atlanta (Ga.).

Georgia Hospital Service Association, Inc., Columbus.

Hospital Service Association of Savannah, Inc., Savannah, Ga.

Idaho Hospital Service, Inc., Boise.

Hospital Service Corp., Chicago.

Mutual Hospital Insurance, Inc., Indianapolis.

Hospital Service, Inc., of Iowa, Des Moines.

Associated Hospitals Service, Inc., Sioux City, Iowa.

Kansas Hospital Service Association, Inc., Topeka.

Blue Cross Hospital Plan, Inc., Louisville, Ky.

Louisiana Hospital Service, Inc., Baton Rouge.

Hospital Service Association of New Orleans (La.).

Associated Hospital Service of Maine, Portland.

Maryland Hospital Service, Inc., Baltimore.

Massachusetts Hospital Service, Inc., Boston.

Michigan Hospital Service, Detroit.

Minnesota Hospital Service Association, St. Paul.

Mississippi Hospital and Medical Service, Jackson.

Group Hospital Service, Inc., Kansas City, Mo.

Group Hospital Service, Inc., of St. Louis, Mo.

Hospital Service Association of Montana, Great Falls.

Nebraska Blue Cross Hospital Service Association, Omaha.

New Hampshire-Vermont Hospital Service, Concord, N.H.

Hospital Service Plan of New Jersey, Newark.

Hospital Service, Inc., Albuquerque, N. Mex.

Associated Hospital Service of Capital District, Albany, N.Y.

Hospital Service Corp. of Western New York, Buffalo.

Chautauqua Region Hospital Service Corp., Jamestown, N.Y.

ROLEE TELEVISION with "MUSIC-TENNA" System can be installed without investment

LEASE OR PURCHASE direct from ROLEE permanent or portable push-around TV. Profit-sharing lease plans relieve your hospital or auxiliary of all investment and maintenance. Purchase prices available on complete or partial installations of equipment. All installations under direct supervision by ROLEE technicians.

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"Patient-Controlled." One speaker used for TV, Radio, Music, Nurse's call and closed-circuit broadcasts.

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Complete "Music-Tenna" cable system includes master TV antenna, AM-FM radio and music over unused TV channels. Nurse's call and hospital TV station optional.

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ULTRASONIC CLEANERS

Curtiss-Wright Ultrasonic Cleaners take the human element out of instrument washing.

Now ultrasonic cleaning action reaches into joints, serrations, and blind holes that hand-scrubbing could miss. Yet the average cleaning cycle drops from 60 to 5 minutes with compact Curtiss-Wright Ultrasonic Cleaners.

Model WB3-25H shown above features the largest tank capacity and an exclusive continual flow filtering cycle that eliminates the need to change detergent with each batch. Cleaning is accomplished without unpleasant noise.

And, most important, a Curtiss-Wright Ultrasonic Cleaner can actually pay for itself. Find out for yourself. Write for complete specifications of the various models and sizes.

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Experience: Longest history of use in practice.

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Convenience: HP*ACTHAR Gel is the only ACTH which can be given subcutaneously—intramuscularly—intravenously (by infusion)

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Supplied: 5 cc. vials of 20, 40, 80 U. S. P. Units per cc. Also in a disposable syringe form, in a potency of 40 U. S. P. Units per cc.

HP*ACTHAR *Gel* is the Armour Pharmaceutical Company brand of purified corticotropin—(ACTH).

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Associated Hospital Service of New York, N.Y.

Rochester (N.Y.) Hospital Service Corp.

Group Hospital Service, Inc., Syracuse, N.Y.

Hospital Plan, Inc., Utica, N.Y.

Hospital Service Corp. of Jefferson County, Watertown, N.Y.

Hospital Saving Association of North Carolina, Inc., Chapel Hill.

Hospital Care Association, Inc., Durham, N.C.

North Dakota Hospital Service Association, Fargo.

Hospital Service, Inc., of Stark County, Canton, Ohio.

Hospital Care Corp., Cincinnati.

Blue Cross of Northeast Ohio, Cleveland.

Central Hospital Service Association, Columbus, Ohio.

Hospital Service, Inc., Lima, Ohio.

Hospital Service Association of Toledo (Ohio).

Associated Hospital Service, Inc., Youngstown, Ohio.

Group Hospital Service, Tulsa, Okla.

Northwest Hospital Service, Portland, Ore.

Hospital Service Plan of the Lehigh Valley, Allentown, Pa.

Capital Hospital Service, Harrisburg, Pa.

Associated Hospital Service of Philadelphia (Pa.).

Hospital Service Association of Western Pennsylvania, Pittsburgh.

Hospital Service Association of Northwestern Pennsylvania, Wilkes-Barre.

Hospital Service Corporation of Rhode Island, Providence.

South Carolina Hospital Service Plan, Columbia.

Tennessee Hospital Service Association, Chattanooga.

Memphis (Tenn.) Hospital Service and Surgical Association, Inc.

Group Hospital Service, Inc., Dallas, Tex.

Intermountain Hospital Service, Salt Lake City, Utah.

Piedmont Hospital Service Association, Lynchburg, Va.

Tidewater Hospital Service Association, Norfolk, Va.

Virginia Hospital Service Association, Richmond.

Hospital Service Association of Roanoke, (Va.).

Washington Hospital Service Association, Seattle.

Associated Hospitals, Inc., Bluefield, W. Va.

Hospital Service, Inc., Charlestown, W. Va.

Marion County Hospital Service, Inc., Fairmont, W. Va.

Blue Cross Hospital Service, Inc., Huntington, W. Va.

Parkersburg (W. Va.) Hospital Service, Inc.

West Virginia Hospital Service, Inc., Wheeling.

Associated Hospital Service, Inc., Milwaukee.

Wyoming Hospital Service, Cheyenne.

Blue Cross of Puerto Rico, San Juan.

Associated Hospitals of Alberta, Edmonton.

Maritime Hospital Service Association, Moncton, New Brunswick.

Ontario Hospital Association, Toronto.

Quebec Hospital Service Association, Montreal.

On our floor
THIS INCERT® SYSTEM IS JUST ABOUT THE MOST! LOOK...IN AN EMERGENCY, WE CAN ADD MEDICATION TO SEVERAL DIFFERENT SOLUTIONS IN LESS THAN A MINUTE!
IT'S FOOLPROOF, TOO. BY LEAVING THE INCERT VIAL IN NECK OF BOTTLE UNTIL READY FOR USE—THERE'S NO POSSIBILITY OF MISIDENTIFICATION.
...AND NO MORE NEEDLES, SYRINGES OR AMPULES TO BOTHER WITH. SAVING ALL THAT PREPARATION TIME IS REAL ECONOMY.
TRAVENOL LABORATORIES, INC. Morton Grove, Illinois

Accreditation problems

(Continued from page 28)

5. *Consultation.* Did the case require consultation according to staff regulations? Was consultation strongly advisable because of the nature of the case? Is the consultant's report adequate and properly recorded?

6. *Operative Cases.* Check the adequacy of the operative report in preoperative diagnosis. Does the final diagnosis agree with the preoperative diagnosis and with the pathological diagnosis, if any? Were there postoperative infections or other complications? Were there adequate indications for surgery? Was normal tissue removed? Why? Was it justifiable or not?

7. *Obstetrical Cases.* If there was operative intervention, were there proper indications for this? Was consultation required? Were there puerperal infection or other complications? What about infant mortality? Were there adequate prenatal care records?

Hospital association meetings

(Continued from page 6)

14 Massachusetts Hospital Association, Boston (Statler Hotel)
18-20 Arkansas Hospital Association, Hot Springs (Arlington Hotel)
18-21 **Hospital Dental Service,** San Francisco (Sheraton-Palace Hotel)
20-22 Middle Atlantic Hospital Assembly, Atlantic City (Convention Hall)
20-22 New Jersey Hospital Association, Atlantic City (Convention Hall)
20-22 Hospital Association of New York State, Atlantic City (Convention Hall)
20-22 Hospital Association of Pennsylvania, Atlantic City (Convention Hall)
24-29 ***National Tuberculosis Association,*** Chicago (Palmer House)
25-27 **Hospital Law,** Boston (Somerset Hotel)
25-29 **Nursing Service Administration,** Cleveland (Pick Carter Hotel)
30-June 4 Catholic Hospital Association, St. Louis (Kiel Auditorium)

JUNE

1-3 ***American National Red Cross,*** Atlantic City, N. J.
1-3 **Advanced Institute for Medical Record Librarians,** Chicago (AHA Headquarters)
1-6 ***International Hospital Congress,*** Edinburgh, Scotland
2-3 Maine Hospital Association, Rockland (Samoset Hotel)
4-5 ***American Geriatrics Society,*** Atlantic City N. J.
8-10 **Administrators' Secretaries,** Chicago (AHA Headquarters)
8-12 ***American Medical Association,*** Atlantic City, N. J. (Convention Hall)
10 Connecticut Hospital Association
10-12 North Carolina Hospital Association, Blowing Rock (Mayview Manor)
12-14 ***Joint Council to Improve the Health Care of the Aged,*** Washington, D. C. (Sheraton Park Hotel)
15-19 **Hospital Pharmacy,** Salt Lake City (University of Utah, Union Building)
18-19 New Hampshire Hospital Association, Whitefield (Mountain View House)
21-23 Michigan Hospital Association, Detroit (Sheraton-Cadillac Hotel)
24-26 Comite des Hopitaux du Quebec, Montreal (Windsor Hotel and Showmart)

JULY

13-17 **Hospital Purchasing,** East Lansing, Mich. (Kellogg Center, Michigan State University)
13-17 **Workshop on Team Nursing,** Chicago (AHA Headquarters)

AUGUST

3-7 **Hospital Pharmacy,** Chicago (University of Chicago)
23-26 ***American College of Hospital Administrators,*** New York City (Statler-Hilton Hotel)
24-27 ***American Association for Hospital Planning,*** New York City (Governor Clinton Hotel)
24-27 ***American Association of Hospital Consultants,*** New York City, (Statler-Hilton Hotel)
24-27 ***American Association of Nurse Anesthetists,*** New York City (New Yorker Hotel)
25-28 ***American Dietetic Association,*** Los Angeles (Shrine Auditorium)

Write for sample unit.

TIME ISN'T ALL YOU SAVE — THINK OF THE ACTUAL DOLLAR SAVINGS IN EQUIPMENT COST AND MAINTENANCE.
. . . . PLUS THE EXTRA HOURS IT GIVES US FOR NURSING CARE.
WISH I HAD HALF THE MONEY THIS HOSPITAL HAS SAVED SINCE WE STANDARDIZED ON INCERT.

Pharmaceutical Products Division of **BAXTER LABORATORIES, INC.**

prn

PRO RE NATA

JOHN H. HAYES

Said the floating night nurse to
the rotating intern,
"This evening I've been all at
sea."
Said the rotating intern to the
floating night nurse,
"My head, too, is spinning,"
said he;
But the rotating intern kept going
around.
Not one of his chores did he
shirk;
And the floating night nurse sailed
along in her job;
For that is how hospitals work.

★ ★ ★

Isn't it about time that someone started a monthly "Readers' Digest" for hospital administrators?

★ ★ ★

If you take chances and win, you are courageous and wise. If you take chances and lose you are reckless and dumb.

★ ★ ★

Officials of New York City have been trying to have off-track horse race betting approved, so as to get additional revenue for the city. If we go that far, why not have lotteries for the benefit of voluntary hospitals? The only difference in these forms of gambling is that the average horse bettor thinks he is betting on a sure thing. The buyer of a lottery ticket isn't so sure.

★ ★ ★

When times are bad there is talk of 30 and 35 hour working weeks, so as to spread the work. When times are good there is talk of shorter weeks so as to provide more leisure time in which to spend the money earned.

★ ★ ★

Evidently the type of article easiest to sell to magazine editors is one in which hospitals and/or doctors are harshly criticized. This is another proof that "man bites dog" stories make news, whether or not they are true.

★ ★ ★

And that reminds me of how annoyed I always get when someone writes about early breakfasts in hospitals. Why should that annoy people who go to sleep two or three hours earlier in a hospital than they do when at home?

★ ★ ★

Do you say, "I never knew how happy I could be until I married", or "I never knew how happy I was until I married"? There is a difference.

★ ★ ★

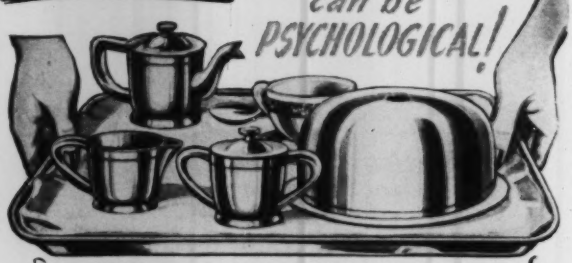
A young student nurse named
Magee
Studied hard, a good R.N. to be;
But a handsome intern
Changed her plans so she'd
earn
No R.N.; but she won her M.D.

★ ★ ★

Nearly all men don't like to work for women.

But: Nearly all men get married.

In the Hospital, "SILVER SERVICE" can be PSYCHOLOGICAL!



. . . also Good Hospital Economics!

EDWARD DON & COMPANY

Letting a patient eat in grandeur, feeling like a queen (or king) for the day does something for morale. That's why so many hospitals serve patients with silverplated tea and coffee pots, creamers and sugars, plate covers, butter dishes, etc. They also serve with good silverware, china, glassware, napkins.

It's good business to do so, too. Patients, especially in private rooms, like to feel they are getting extra service in more ways than one. It's good "guest" relations and—you know how patients afterwards talk about their operations—it proves to be good publicity, too.

Silverware and other fine serviceware are only a few of the 50,000 items of Equipment — Furnishings — Supplies sold by DON for hospitals and other institutions. What are your needs now?

Write Dept. 7 for a DON salesman to call.

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a penny saved is a...

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MEDICAL TECHNOLOGIST: To supervise clinical laboratory in 300-bed hospital. ASCP registered. Experience. Prefer Bachelor degree. 40-hour week with minimum call. Liberal benefits. Salary open. Apply to hospital administrator, St. Johns Hospital, St. Paul, Minnesota.

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DIETITIAN: registered A.D.A. or eligible . . . for 160 bed hospital in Pennsylvania. Liberal vacation, holidays and sick allowance. Salary open. Madeline Gregory, Administrator, Miners Hospital of Northern Cambria, Crawford & First, Spangler, Penna.

CHIEF DIETITIAN: Administer and direct dietary program. A.D.A. registered. Experienced in dietary department administration. 185 bed J.C.H.A. approved general hospital with excellent facilities. Approved diploma school of 150 students. Excellent working condition, personnel policies, and very attractive salary. 95% of active medical staff is board certified. Contact, Byron D. Jackson, Administrator, St. Luke's Hospital, Fargo, North Dakota.

OPERATING ROOM SUPERVISOR: 129 bed and 22 bassinet fully accredited hospital—location central to Boston, Providence and Cape Cod—Taunton, Massachusetts. Special clinical preparation in supervision, B. S. desired. Surgical Technician program under consideration, qualified surgical staff, excellent personnel policies. Salary open depending on qualifications and experience. Write Director of Nursing Service, Morton Hospital, Taunton, Massachusetts.

ADMINISTRATIVE SUPERINTENDENT: for State Mental hospital located Jamestown, North Dakota. Salary open, plus full maintenance. Hospital population approximately 1,800. Requirements—At least five years experience as Hospital Administrator. Contact H. H. Joos, Chairman, State Board of Administration, State Capitol Building, Bismarck, North Dakota.

STAFF NURSES, (3): Fifty bed hospital, small community near St. Louis, prevailing salary, paid vacation, paid sick leave, expanding facilities. Address replies to Mr. Robert E. Harper, Jr. Administrator, Lincoln County Memorial Hospital, Troy, Missouri.

LABORATORY TECHNICIAN: Brightlook Hospital, St. Johnsbury, Vermont. 52 bed accredited general hospital. Laboratory in charge of a registered medical technologist and part time pathologist. Salary dependent on qualifications. Communicate with Ralph H. Ross. Administrator.

NURSES: Registered; general duty and operating room. Modern 74 bed District Hospital, midway between San Francisco and Los Angeles, Calif. Starting salary $325.00 per month, 5 day week. Contact Administrator, Tulare District Hospital, Tulare, California.

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RECORD LIBRARIAN: registered or eligible for 160 bed hospital in Pennsylvania. Liberal vacation, holidays and sick allowance. $300 starting salary. Madeline Gregory, Administrator, Miners Hospital of Northern Cambria, Crawford & First, Spangler, Penna.

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REGISTERED NURSES WANTED: For operating room supervisor and general floor duty. 57 bed hospital. Details furnished on request. Contact: Administrator, Sid Perterson Memorial Hospital, Kerrville, Texas.

FEMALES: St. Luke's Hospital, New Bedford, Mass. O.R. Supervisor, Clinical Instructor, O.R. Nurses, Staff Nurses, Modern 350 bed hospital in lovely New England community near Cape Cod. Salary commensurate with education and experience. Excellent benefits. Apply Personnel Director.

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